Delivering Culturally Competent Services to Women & Children Who Are Affected by Drugs

Edited by

DARLENE GRANT, Ph.D.

JEANNE PIETRZAK, M.S.W.

RICHARD P. BARTH, Ph.D.

National Abandoned Infants Assistance Resource Center

School of Social Welfare • University of California at Berkeley

Delivering Culturally Competent Services to Women & Children Who Are Affected By Drugs

Edited by

Darlene Grant, Ph.D.
Jeanne Pietrzak, M.S.W.
Richard P. Barth, Ph.D.

This report should be cited as: Grant, D., Pietrzak, J. & Barth, R.P. (1997). *Delivering Culturally Competent Services to Women & Children Who Are Affected by Drugs*, Berkeley, CA: National Abandoned Infants Assistance Resource Center, School of Social Welfare, University of California at Berkeley.

For additional copies of this monograph or a list of additional publications, call or write:

National Abandoned Infants Assistance Resource Center
1950 Addison, Suite 104
Berkeley, CA 94704-1182
Ph: 510/643-8390
Fax: 510/643-7019

TABLE OF CONTENTS

PUBLISHER'S ACKNOWLEDGEMENTS

This monograph represents a team effort waged by many dedicated people and organizations.

The project sprung from the creativity, vision and passion of co-editor, Darlene Grant, a former evaluator of a federal Abandoned Infants Assistance (AIA) demonstration project. It was conceived of at the 1993 AIA Grantees' Conference in Washington, D.C., an annual meeting co-sponsored by the Children's Bureau and the National Abandoned Infants Assistance Resource Center. Dr. Grant gave generously of her time, energy and imagination in order to launch this demanding project.

The authors are to be commended for their contributions and their perseverance through a long editing and publishing process. Each author understood the need to provide information that practitioners can readily grasp and use. Special thanks goes to Renee Robinson for preparing the edited manuscript for publication. The services of Betsy Joyce of Betsy Joyce Graphic Design and Jack Vanden Brulle of Apollo Printing are gratefully acknowledged. The support of our federal project officer, Pat Campiglia, is also appreciated.

This monograph was made possible by a grant to the National AIA Resource Center from the Children's Bureau, Administration on Children, Youth and Families, U.S. Department of Health and Human Services and by administrative support from the University of California, School of Social Welfare.

FOREWORD

The material presented in this collection of papers is based upon the experiences of former and current AIA practitioners, administrators and researchers who have strived to develop multicultural competencies in their work with ethnically and culturally diverse families affected by perinatal substance abuse and HIV. The authors explore various aspects of cultural sensitivity and competency, suggest strategies for agency self-assessment and improvement and propose changes in clinical practice to enhance its effectiveness.

We hope that this monograph will prove to be a useful guide for efforts to increase cultural competence so that services provided by human service organizations can be maximally effective.

Darlene Grant, Ph.D.
Jeanne Pietrzak, M.S.W.
Richard P. Barth, Ph.D.

Austin, Texas and Berkeley, California

INTRODUCTION: AN OVERVIEW

Darlene Grant, PhD

While culturally sensitive service delivery is now widely accepted as sound professional practice, there will always be those who continue to question the basic premises: What's culture got to do with it? Why do we have to focus on our differences? Isn't focusing on our differences divisive? Why can't we focus on our strengths and all just get along?

Simply put, culture has everything to do with it. Culture is the medium through which everything that happens around us flows, as it is input into our minds, souls and hearts and is responded to in our behavior, thoughts, feelings and words. Cultural issues may directly and/or indirectly obstruct or enhance the development of programs, policies and procedures, diagnosis and treatment plans; program accessibility; women's recovery; and workers' advocacy skills in micro and macro levels of practice. If we consider the petri dish metaphor of culture as "living material in prepared nutrient media," (Merriam-Webster's Collegiate Dictionary, 1993), then the ideal of cultural competence is one of preparing the most nutritious environments to promote change; individual, family and group recovery; enhancement; growth and empowerment. This monograph seeks to communicate the experiences of practitioners working in the trenches to "prepare nutrient media" for women -- pregnant and parenting -- who are experiencing problems with drug addiction.

Our goal, with this monograph, is to highlight national efforts towards the ideal of cultural proficiency in serving pregnant and parenting women who use drugs. Cultural proficiency is defined by Cross, Bazron, Dennis, and Isaacs (1989) as:

> *The most positive end of the [cultural competency] scale. This point on the continuum [in contrast to cultural destructiveness; cultural incapacity; cultural blindness; cultural pre-competence; cultural competence] is characterized by holding culture in high esteem. Culturally proficient agencies [and individuals] seek to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects. Culturally proficient agencies hire staff who are specialists in culturally competent practice. Such agencies advocate for cultural competence throughout the system and for improved relations between cultures throughout society.*

All of the authors featured in this monograph have worked in some capacity with federal Abandoned Infant Assistance demonstration projects and actively support the development of cultural competencies. Each chapter, in the monograph, presents a practice capsule, offering the individual reader a catalyst for heightened awareness and change in relation to intervention with culturally

diverse clients. The discussions presented in this monograph are suggestive of the need to consider the client's cultural frame of reference as it impacts help-seeking behavior and the worker's or agency's cultural frame of reference as it facilitates or hinders help-seeking, compliance and noncompliance, satisfaction and dissatisfaction with services and subsequently, treatment success and failure.

In Chapter 1, *Campt and McKinney* address issues of assessment and implementation of cultural competent practice in social service organizations. A conceptual understanding of the macro constructs of service delivery and culture is key to an organization's assessment of it's cultural competence. Four varying levels of culture reflected by agencies, staff and clients are profiled: meaningful cultural expressions; patterns of behavior and communication; values and beliefs; and underlying philosophies/world views. The process of choosing the level(s) of culture to be implemented in an organization is acknowledged as a challenging task that is subjective and often political in nature. Organizations are encouraged to assess the cost and benefits of various types of changes.

Jones, Buntz, Hutchins, and Childress maintain, in Chapter 2, that prospective clients informally assess the environment and staff of treatment programs for sensitivity to a number of their needs and issues, including cultural sensitivity and competency. They suggest that the results of this informal assessment are important in the decision of women of color to enter or not enter treatment programs. The authors examine the factors reported by African-American women as important to making them feel comfortable in the therapeutic program setting.

In Chapter 3, *Donoghue and Wright* examine institutionalized obstacles to service utilization, including screening bias, language barriers, and program rules based on belief and value systems that devalue what is important to women of color. The authors suggest that clients, current and prospective, know when staff are merely tolerating their differences, as opposed to being genuinely interested in their whole selves.

Davis and MacDonald, in Chapter 4, present a program specific intake and pre-intake approach to affecting change in the trend of under-utilization of drug-addiction treatment by African-American women. The authors suggest that the percentage of African-American women who do not enroll in drug-addiction treatment services after initial contact is reduced significantly for women involved with a front-line, multidisciplinary team, composed of substance abuse specialists, a community health nurse and a clinical social worker.

The synergistic effect of race, culture, family, addiction and poverty on child rearing and mother-child interaction are examined by *Adnopoz, Washington, Nagler and Wyatt* in Chapter 5. Drawing upon a "universal needs paradigm", information from the literature and practice experience is reviewed, in noting the relationship between consistency in the parent-child relationship and the child's progressive growth and development.

In Chapter 6, *Adesanya and White-Tennant* examine infant development and the mother-child relationship within African-American culture and contrast "healthy development" with development impacted by drug-addiction and HIV exposure. The authors review the universal purpose and utility of the Bayley Scales of Infant Development and suggest that strict and inflexible adherance to this instrument may provide service providers with inaccurate pictures of African-American children. The authors discuss the importance of culturally sensitive clinical observation and assessment.

The ideal of cultural competence shines through in different, and sometimes similar, ways in each of the chapters presented. The sum total suggests that cultural competence is itself complex, contextual, and composed in part of what each individual and group brings to the table. As a whole, this monograph further suggests that evaluation of culturally specific and competent services remains a realm of challenge as the effectiveness of individual and coordinated services are unclear. Research and evaluation that determines the services which are helpful or not with particular subgroups of women should be a component part of all program development.

It is apparent throughout this monograph that the colorfulness, the richness and the positiveness of racial and cultural differences in clients and workers contribute to women's willingness to enter the doors of our programs, their willingness to entrust themselves to our care, and our willingness to empower them to fight and struggle with their addiction and to grow in their parenting responsibilities and skills in ways most meaningful to them. It is from this focus and philosophy that we speak. It is from this focus and philosophy that we wish to empower drug-addicted women to change and to help those working with these women to make ethical, clinically sound, culturally sensitive and culturally competent practice assessments, decisions and recommendations.

As direct service providers, program administrators and consultants, we must prepare ourselves to withstand the range of reactions (internal and external; personal and organizational) to the questions we pose and the answers we find when committing ourselves to understanding cultural diversity and growing in our commitment to developing multicultural competencies. The reader is challenged to mature in knowledge and sensitivity to the point of moving past limited knowledge, fear, anger or guilt-driven justification of their own position on the subject of cultural diversity. With efforts like this monograph, we demonstrate our ability to respond sensitively to the myriad needs of drug-addicted women and children from all ethnic and cultural backgrounds.

References

Cross, T.L., Bazron, B.J., Dennis, K.W., and Isaacs, M.R. (1989). Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed. Washington, DC: Child and Adolescent Service System Program Technical Assistance Center, Georgetown University Child Development Center.

Merriam-Webster (1993). Merriam-Webster's Collegiate Dictionary, 10th Ed. Springfield, MA:

Chapter 1

DEFINITIONS OF CULTURAL COMPETENCE AND EFFECTIVE PROGRAM IMPLEMENTATION IN SOCIAL SERVICE DELIVERY

David Campt, MPP, PhD
Center for Reproductive Health Policy
Clearinghouse for Drug-Exposed Children
University of California at San Francisco

Lora-Ellen McKinney, PhD
John F. Kennedy School of Government
Harvard University

Introduction

In the United States today, there is an expanding vocabulary of human service terms and concepts: diversity, cultural competence, multiculturalism, and cultural sensitivity are just a few. These terms indicate a growing acceptance of the notion that personal or group differences based on racial and/or ethnic group, religious affiliation, and sexual orientation have value, validity and importance. Many citizens in the United States found that the determined and deliberate egocentrism of the 1980s and its related solitary pursuits were not only lonely and dangerous, but were perhaps counter to our natural instincts towards "community" as well. There has been a concerted effort in the 1990s on the part of many groups to find or rediscover factors that can consolidate community. It is not surprising that this rediscovering and redefining of community has become the focus of many of our social service organizations.

The new focus of service and community has extended to assessment of organizational competence in hiring policies, concern about inadequate representation of traditionally underrepresented groups, and use of acceptable terminology to address and describe various racial, ethnic, sexual, or other interest groups. Despite the recognition of difference as a positive force within organizations and the larger society, it has also become increasingly clear that there is no well defined definition for this range of ideas. Even without definitional clarity, many funding agencies require that their grantees be culturally competent and demonstrate their cultural specificity and sensitivity. Agency hiring practices, in fact, may be based on the degree to which the potential employee recognizes the value of the concept.

Thus, cultural competence has increasingly become a buzzword that signifies that the user is aware that certain forms of organizational discrimination and myopia are no longer acceptable (Cross, Bazron, Dennis & Isaacs, 1989). Beyond this, however, few guidelines exist which describe how to improve an organization's cultural competence. In an attempt to respond to internal or extraorganizational imperatives for increased competency, some organizations have taken on major changes in their personnel and treatment design, while others have instituted changes that might be called cosmetic (e.g., celebrating different holidays, ethnic food nights). Clearly, service providers need a framework for understanding the degree to which these very different activities can legitimately be called improvements in cultural competency. Similarly, organizations need a clear and practical set of ideas that will guide the development of organizational structure and policy, program planning and service initiatives, and treatment goals and outcomes.

This chapter is designed to provide the reader with a road map for increasing the cultural competency of service programs. This road map will be presented by giving the reader: (1) a conceptual schema for thinking about the various elements of culture and of service delivery; (2) factors that influence the degree of organizational change that an agency is willing to consider; (3) an illustration of how well intentioned services can be culturally incompetent and ineffective; and (4) methods for ensuring that cultural competence and assessment remains an integral component of an organization's activities.

This chapter demonstrates a field-tested approach for guiding organizations through the steps necessary to improve the cultural competency of their services. The approach described here has been used by the authors to assist perinatal drug treatment organizations as well as agencies that provide other types of human services. In addition to helping organizations improve their cultural competency, the approach described is designed to provide a general framework for understanding what cultural competency is, and for putting diverse efforts to improve cultural competency in context.

Definition of Cultural Competence

For the purposes of this chapter, culture is defined as the integrated pattern of human behavior that includes the thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group (Cross, Bazron, Dennis & Isaacs, 1989). In our definitional view of a culturally competent system the individual and organization:

- acknowledges culture as a primary force in shaping behaviors and values, and incorporates appropriate and relevant cultural factors at all levels of the program;

- views natural systems (i.e., family, community, church, healers) as a primary means of support for people of color, and acknowledges that people are served in varying degrees by these systems;

- recognizes that people of color are also affected by the mainstream culture, and that the effects of both cultures sometimes cause distinct mental health issues, such as low self-esteem.

A Well-Intentioned But Culturally Incompetent Effort

In the mid 1980s, a U.S. city with a very large gay and bisexual community was experiencing a devastating increase in the numbers of people diagnosed with HIV infection. In response, the public health department and concerned community members instituted an HIV prevention campaign that focused on providing basic information and changing attitudes. The campaign involved an intensive effort to discuss HIV and AIDS with gay and bisexual men, and to invite them to visit a gay community/information center that had been established in a central location.

The information center was designed to make gay men feel welcome, and was therefore adorned with gay-oriented artwork and with information brochures aimed explicitly at gay and bisexual men. Visitors to the center were also encouraged to fill out surveys discussing their sexual practices so that health officials could better understand community risk factors, predict infection rates, and describe, for statistical and educational purposes, sexual practices and behaviors typical among this population of gay and bisexual men. While visiting the center, the men would also engage in a discussion about the health benefits of practicing safer sex. Specifically, they were asked to consider that adopting a safer sex approach would not only save their own lives, but was also important to ensure the survival of the extensive and politically strong gay community in the city.

By the reports of the city's health officials, the HIV education campaign and the research and community discussion format of the education center were quite effective. Statistics showed that within two years a variety of HIV-related attitudes and risk behaviors had changed. Studies indicated that white gay and bisexual men were more knowledgeable about HIV transmission, were getting tested more frequently, reported more positive attitudes about the use of condoms, were practicing safer sex, and were effectively using the gay community information center that had been established.

To the surprise of both public officials and gay community leaders, however, African-American gay and bisexual men did not evidence strikingly similar changes in these indicators. As a result, the community and public officials decided to target this segment of the gay population. The effort to redouble the commitment to educate African-American gay men occurred on several levels. Community health volunteers were instructed to target gay and bisexual African-Americans at gay celebrations, gyms, bars, and other gathering places. Officials at African-American churches were contacted by telephone and informed that they would receive information packets that could be made available to African-American gay congregates. When African-American gays entered the information center, the staff were encouraged to be extra friendly to them, and to

introduce themselves personally so that the visitors would be on a first-name basis with a person working for the center.

Public health officials recalled learning that African-Americans often distrusted research efforts because of the history of unethical medical experimentation involving people of color as research subjects in the United States. To make completion of the survey more comfortable for them, volunteers were instructed to make a special effort to assist African-American potential clients with the survey, if they so desired. The center staff would give the center's African-American clients the message to "fight against the spread of HIV" for community survival, and encourage them to participate in the safer sex parties and gay support groups that had been organized in the community.

After two additional years of this effort, community and public officials reviewed the program and discovered several disappointing facts. The outreach effort had been only marginally successful in bringing more African-American gay and bisexual men into the information center. Staff in the center reported that African-American clients often seemed uncomfortable, and would sometimes leave before the business related to their visit was completed. Follow up surveys revealed that African-Americans who visited the center did not change their attitudes about safer sex as much as whites. The follow up efforts also revealed that African-American attendance in the support groups and safer sex parties had not noticeably increased.

There is no question that the public health officials in this city were well intentioned in their efforts to decrease the citywide incidence of HIV infection. There was also undeniable evidence that their efforts had succeeded for one racial population and not for another. Were their efforts shortsighted? Had they planned poorly? What necessary factors had not been considered in determining how to reach the entire community of gay and bisexual men effectively? Might a lack of cultural competence have contributed to the ineffectiveness of the program?

Analyzing Culture and Service Delivery

In order to understand fully the degree to which the HIV education effort may have failed because of cultural incompetence, it is necessary to have conceptual understanding of the macro constructs of service delivery and of culture.

Any social service agency's activities can be conceptualized as comprising five separate functions, as indicated by Table 1.1. The agency must have some outreach strategy in order to garner the attention of potential clients. Usually this happens via outreach workers, literature and flyers, other media, and contact with other agencies.

Having attracted potential clients' attention, the agency must provide a comfortable environment. This is done by insuring a pleasant physical atmosphere and decor, appropriate literature, and positive interactions between staff members and between staff and clients. An agency's primary

goal, enhancement of the client's functioning, is achieved by the actual intervention, which involves both assessment and treatment. The strategies for these phases are embodied in the assessment tools and the treatment modality, which are typically determined by the entire organization or its leadership. All of these organizational activities are conducted by individual providers, who bring to their personal interaction with clients unique sets of strengths, weaknesses, quirks, and preferences. Lastly, effective organizations use their intraorganizational linkages and professional networks to make referrals designed to maintain or bolster the agency's intervention and effectiveness.

Table 1 .1

Five Aspects of Any Social Service	
1. Outreach	Making contact with people who may benefit from the service and engaging for follow-up contacts/services
2. Organizational Atmosphere	Insuring a comfortable setting for potential and ongoing clients
3. Intervention	Strategy for change in the client's life and client's environment
A) Assessment	Determining the client's problem
B) Treatment	Goal of enhanced client functioning
4. Personal Interaction	Individual qualities that providers bring when relating to clients
5. Extra-organizational Linkages	Referrals to other agencies to reinforce improved client functioning and change

While the foregoing may be obvious, and is not comprehensive, it is provided here so that the following discussion of organizational cultural competency can be understood in terms of specific organizational activities. For instance, an organization might have difficulty attracting Latino clients but have good success in treating them once they choose to participate. At the same time, it might be successful in enrolling African-Americans, but fail to provide them with effective treatment. By separating the organization's activities into discrete functions, providers can more effectively target their efforts or pinpoint their weaknesses.

Making Cultural Competence Work for Your Service Organization

Much more difficult than understanding service delivery is finding a conceptual framework for capturing the diverse set of activities comprised in the term "culture." Any definition of the term is likely to be so broad as to be virtually meaningless. As noted in the section on definition, the important concern is actually not defining culture, but rather developing a lens to draw one's attention to the specific aspects of culture that may be relevant to the organization's activities.

The authors have used the conceptual map presented in Table 1.2 to help organizations understand culture and cultural differences. The most visible aspect of culture concerns food, music, visual artwork, important holidays, and the like. These aspects of culture might be called "tangible cultural expressions" and by their nature are quite apparent to any observer. Salsa music, Kwaanza ceremonies, and Japanese flower arranging are examples.

Table 1.2

Conceptual Map: Understanding Culture and Cultural Differences

Types of Cultural Elements Reflected by Agencies, Staff, and Clients	
Level 1: **Meaningful Cultural Expressions** *examples: food, music, decor, celebration of holidays*	relatively easy to articulate may require minor changes in program
Level 2: **Patterns of Behavior and Communication** *examples: language, ways of socializing, recreational activities, parenting behaviors*	possibly difficult to articulate may require moderate changes in program
Level 3: **Values and Beliefs** *examples: family and gender roles, attitudes towards intoxication, role of relationships*	difficult to articulate may require substantial changes in program
Level 4: **Underlying Philosophy/World View** *examples: purpose of life; relationship between God, humans, and nature; mission of individual, family, and group*	very difficult to articulate may require intensive overhaul of program

Slightly more subtle than tangible cultural expressions are the patterns of behavior and communication. This aspect of culture encompasses the way that people of a group socialize, interact, recreate, and parent children. This includes, for example, language and dialect, the way that physical distance and eye contact are used in conversations, and body language. Examples include the ways that some Latinos speak by combining English and Spanish, the way that some African-Americans playfully use verbal assaults ("playing the dozens"), or the practice in some Asian cultures of not looking directly into the eyes of an elder or perceived superior.

More embedded in human behavior are values and beliefs. This aspect of culture largely concerns the underlying notions that guide and inform the meanings people place on their interactions with the physical and social world. For instance, cultures vary in their definitions of family and familial obligations, the definition of appropriate male and female behavior, the importance placed on physical, verbal, and mental skills and so on. This aspect of culture might include some Latino's concept of *personalismo,* the understanding of some African-Americans about the pervasiveness of racism, or the importance some Asian groups place on family traditions.

The most embedded layer of culture includes the philosophy and world view that has traditionally been the basis of civilization from which the culture emerges. This layer concerns how the culture approaches broad questions, such as the relationship between humans, nature, and a higher power, or an individual's mission in life. Examples are: the primacy of the individual in some European cultures, the importance of order in some Asian cultures, and the importance of submitting to God's will in African-American culture.

It is important to recognize that there is substantial overlap and interaction between adjoining cultural layers. One might maintain that any particular activity is a tangible cultural expression, embodies patterns of behavior, reflects a particular culture's values, and highlights a civilization's philosophy all simultaneously. These layers are not meant to be entirely mutually exclusive, but rather to contribute some additional clarity to an effort to contemplate how cultural factors affect people and organizations.

The preceding analyses of culture and service delivery can help explain some of the confusion about cultural competency. For example, some programs have changed their dietary programs, holidays celebrated, and the music and artwork in their facilities in the name of cultural competency. Other programs have used the same rationale to justify training staff and clients in "Effective Latino Parenting" (to use one ethnicity as an example). Still others have integrated intensive discussion of societal racism into the treatment setting, while others have attempted to reconnect clients with a particular cultural notion of harmony between humans and the earth. To some, this diversity of approaches leads to cynicism about whether cultural competency has any meaning. The model of culture presented here attempts to put these disparate efforts into

perspective. Most efforts to improve cultural competency can be thought of as focusing on specific levels of culture (as well as some specific set of organizational activities). In the above examples, the layer of culture focused upon varies from that comprising tangible culture expressions to those emphasizing underlying philosophy and world view.

Which Level of Culture Merits Attention?

The task for the organization is to increase and maintain cultural competency for the groups it serves, while consciously assessing the costs and benefits of various types of changes. Although each organization must make such assessments for itself, the authors offer speculations about the likely tradeoffs between changes at various levels of culture.

Generally, changes at Cultural Level One are relatively easy to implement. When an organization contemplates a change with respect to *tangible cultural expressions* -- such as celebrating cultural holidays, making changes in the menu, or playing different radio stations -- these changes are often not met with much resistance by current staff; they may not require much staff or organizational reassessment. In fact, employees may appreciate getting an additional slice of cultural life at work. At the same time, these changes are not likely to have a significant effect on client participation or recovery. The music, artwork, holidays, and food can all serve to help clients feel more comfortable because clients may feel that these expressions show that the organization reflects their cultural identity. These changes are important in assuaging client skepticism, but may not play a major role in making the intervention more effective.

Making organizational changes to account for *cultural patterns of behavior and communication* (Level 2) may require significant adjustment by the agency. Staff may need to reevaluate their positions about such issues as the definition of child abuse, the importance of promptness, or what constitutes appropriate conversational topics or conversation volume. These types of changes require more adjustments to individual provider and agency behavior, and some staff may resist these changes unless they are sufficiently convinced about the rationale for these changes. Staff may even undermine the changes because they prefer the previous agency atmosphere.

If an organization more effectively accommodates people's behavior and communication patterns, it increases its capacity to help clients feel that they must be open to provider efforts to draw out the individual and group emotional issues in order to begin recovery. Essentially then, organizational adjustments at Cultural Level 2, in comparison to Cultural Level 1 are more difficult for the agency, but more likely to bring about institutional and client change.

Adjusting the treatment setting to consider clients' *cultural values and beliefs* (Level 3) may bring about more client change, but require even more effort from the organization. If, for example, an agency accommodates clients' beliefs about racism, definitions of family, or notions of spirituality and religion, staff may have to rethink some aspects of current treatment modalities. To continue with these examples, the organization may need to discuss societal, organizational, and individual racism within the treatment setting, include the client's definition of family in treatment, or forge relationships with religious officials. Such changes require significant effort, with providers reexamining their own personal values and treatment preferences, and perhaps their definition of professional ethical behavior. Yet, because the recovery efforts are largely aimed at changing clients' values and beliefs about themselves and substance abuse, understanding and working with client perspectives on this level of culture may have significant potential for fostering positive client change.

Some programs, often focused on a particular ethnicity, have attempted to fashion treatment approaches around the essential *philosophical orientations* of a particular culture (Level 4). Such programs operate from the basic presumption that clients' addictions are inextricably linked to falling out of touch with their culture. These approaches, however, require a substantial redesign of conventional addiction treatment approaches. One prominent example involved an intensive effort to reformulate the 12 Steps Model. If successful, these programs can provide clients with a philosophical outlook which can pervade every aspect of their lives. These efforts may, in fact, represent the greatest potential for fostering client change. Clearly, however, reconstructing a program so that it reflects a different philosophical underpinning requires an extensive effort by staff and management, and such an effort will almost certainly and understandably encounter heavy staff resistance and skepticism.

Defining a culture's philosophical precepts is both an interpretive endeavor and a political one, and people will have legitimate and deeply held differences of opinion. Working through these differences will undoubtedly require substantial effort.

At this point, there is no research about cultural competency that examines the relative effectiveness of each of these types of approaches, although that will likely change in the next several years. Even before that research is completed, organizations and cultural informants must evaluate the tradeoff between the degree of organizational change it is willing to consider and the likely effect. In their work with treatment and other human service organizations, the authors typically encourage agencies to examine the culturally influenced values and beliefs of their clients because the tradeoff between organizational change and client benefit appears to be quite promising.

Step-by-Step Guide to Improving Cultural Competence

Based on our experience consulting with organizations attempting to improve cultural competency, we offer this step-by-step guide to these efforts. Table 1.3 provides a seven step self-assessment tool for increasing organizational cultural competence.

Table 1.3

Seven Steps for Designing a Culturally Competent Program: Guidelines for Self Assessment

1. Strengthen organizational commitment to cultural competence and begin to articulate relevant questions about program effectiveness.
2. Commit organizational resources to improving cultural competency.
3. Secure management validation of the cultural expertise that will inform the cultural competence improvement effort.
4. Compare agency's embedded assumptions to cultural realities.
5. Brainstorm potential improvements, build consensus, and identify potential obstacles.
6. Implement changes, and remain flexible.
7. Institutionalize organizational commitment to cultural competence.

Step One: Strengthening Commitment and Articulating Questions

As has been discussed, efforts to improve cultural competence can be as simple as altering menus, or as complex as inventing a new treatment modality. While it is important that the effort to improve cultural competency be constructed in a way that ensures staff commitment, it is nevertheless true that the initial openness to the effort on the part of staff and management can greatly affect whether the effort is successful. One way to persuade skeptical staff about the need to examine cultural issues is to identify gaps in service to particular ethnic groups. For instance, a

program may have records which, if examined with race, ethnicity, and culture in mind, may indicate difficulties in recruiting, retaining, or preventing relapse among certain populations. When disseminated within the organization, these statistics can convince skeptics of the importance of examining cultural questions.

Even if such statistics are not available, an organization usually has at least a few staff who have a sense that the agency may not be serving certain clients of color as well as it should. It is critical that these staff members articulate their concern to others, including those who are skeptical about the relevance of culture and cultural differences. Doubt about the degree to which an organization is serving its clients of color often leads to organizational self-examination. The questions that propel this necessary doubt can be as broad as, "Are we actually serving our clients of color sufficiently?" or as specific as, "Why are we unable to get Latinos in the northern counties to come for treatment?"

Step Two: Commit organizational resources to improving cultural competency

Many providers feel that improving cultural competency can be accomplished by attending just one training session, or even by just making a "personal commitment" to dealing with culture more effectively. The reality is that society's history of racial and cultural oppression makes it very difficult for people to discuss these topics with sufficient consistency to foster actual organizational improvement. On the other hand, even though cultural competency is an issue around which organizations must be externally vigilant, providers do have other issues that require attention. It is important that staff and management commit a substantial and specific amount of time to examining the cultural implications of agency activity. The commitment to improve cultural competency must not be either a one-shot inoculation nor a black hole into which infinite amounts of time must be committed.

Step Three: Secure management validation of the cultural expertise that will inform the cultural competence effort

People with substantial experience and expertise in the cultures at issue have a major role to play in articulating concerns and questions regarding an organization's cultural competence and providing an accurate reflection of cultural realities. This expertise can come from a variety of quarters, including staff, clients, consultants, and community members. Regardless of the source of expertise, it is essential that management acknowledge that these experts have knowledge that is lacking in the organization. Organizations should avoid relying on cultural experts who are not part of the cultural group under consideration. Articulating cultural realities in a way that is meaningful but does not promote stereotyping is a difficult and tricky endeavor, even for people within the culture being discussed. These realities can be discussed more effectively if they have been experienced rather than observed by the expert.

Step Four: Compare agency's embedded assumptions to cultural realities

From the briefest eye contact to the structure of the treatment regimen, each provider and every organizational action contains embedded assumptions about how people will respond. These embedded assumptions are grounded in some cultural understanding, although perhaps from a culture that is different than that of current clients. The organization must specify which organizational activity is of concern, then examine the embedded assumptions. The cultural experts can then assess the degree to which these assumptions are compatible with their cultural population.

This process is not mysterious, and is what essentially happens when, for example, minority clients request that the music in a waiting room be changed from country/western to urban contemporary. At the level of tangible cultural expressions, disparity between current organizational assumptions and cultural realities are easy to observe. Engaging in this process at more subtle, but perhaps more important, levels of culture requires much more participation by cultural experts, and much more commitment to self-examination by providers and organizations.

This examination should also provide an opportunity for providers to reflect upon their personal attachments to the cultural reality being discussed. If people are not encouraged to articulate their perspectives, and recognize them as their own, they are more likely to unconsciously resist changes made with respect to these realities. For example, many people expert on the topic of African-American culture advocate that treatment programs recognize the importance of the extended family, and perhaps include these family members in treatment efforts. An agency's management, after going to a cultural competence training, might make such programmatic changes. However, these changes may be passively opposed by a treatment staff person, perhaps because he is unconsciously envious of the fact that he never had a loving, extended family. Or, a staff person may simply disbelieve that the extended family is actually a reality for clients. If staff are encouraged to articulate their perspectives about the cultural realities being discussed, they are forced to confront the fact that they are, in fact, expressing their *opinions,* not a knowledge of "reality." This process diminishes the likelihood that these perspectives will undermine organizational change efforts.

Step Five: Brainstorm changes, build consensus, and assess obstacles

Having articulated the assumptions behind the current approaches and obtained cultural expertise about other cultural realities, the organization is in a position to brainstorm ideas for changing the organization's activities so that they are more effective for the cultural group being discussed. It is important that staff distinguish between strategies that can be implemented individually, those that can be implemented through an informal commitment of

staff, and those that require management commitment. These distinctions are important to recognize because even after the most inclusive and cooperative discussion of the cultural issues affecting agency activity, people will still vary significantly in their perception of the degree to which cultural issues matter. These differences of opinion need not threaten the improvements in cultural competency if there is an agreement that some of the changes can be implemented at the individual provider's discretion. Recognition of differences of opinion can also make it possible to build consensus around areas of common agreement, and to take collective action.

It is also useful for staff to contemplate the obstacles to implementing their perception of culturally competent service changes. Whether the changes are as minor as using ethnically specific dolls or as major as empowering clients by raising their political awareness, changes to increase cultural competence are usually met with some resistance. Like any organizational change, efforts to improve cultural competency can be made more effective if such obstacles are anticipated and planned for.

Step Six: Institutionalize organizational commitment to cultural competence

Clearly, the questions of an agency's cultural competence vary significantly depending on the type of service being provided. What follows are some questions commonly confronting such programs (Table 1.4).

The HIV Prevention Example

This chapter began with a description of an HIV prevention campaign that appeared well-conceived but turned out to be ineffective for a particular cultural group. The framework presented throughout this paper provides a format for discussing the cultural incompetence of that service.

The outreach effort was based in part on an effort to target blacks who participate in gay organizations and gay social institutions more effectively. This strategy ignored the fact that many African-American gay men do not participate in mainstream (that is, white) gay organizations and social clubs. The outreach effort also involved sending HIV prevention information to African-American churches, so that African-American gays could be reached in that way. However, *many African-American churches are unwilling to acknowledge their gay membership.* Because the assumptions embedded in the outreach approaches differed from these cultural realities, the efforts were ineffective.

Table 1.4

Common Questions for Improving Cultural Competence
Outreach: How do we find clients? Where do clients gather and hang out? What does our literature communicate about who the organization serves?
Organizational Atmosphere: How have we altered our approach for welcoming clients to reflect our interest in clients of color? How would clients of diverse ethnicity perceive the following characteristics of our organization: • attitude of reception staff? • attitude towards time? • artwork? • music? • holidays acknowledged? • definition of appropriate conversation? • recreational activities encouraged? • authority style? • decor? • food? • noise level? • educational materials? • language?
Structure of Intervention: How should ethnicity and culture affect our approaches to assessment and treatment? Have we explicitly examined the embedded assumptions in our approaches for cultural relevance?
Assessment: Are we using culture-bound indicators as we assess the clients': expressions of anger? "co-dependency"? concerns about fair treatment? child "abuse"?
Treatment: Have treatment approaches been adjusted to the different psychological and social circumstances of people of color? What assumptions do we make about client motivation and client resistance? Specifically, what does our treatment modality assume about the clients': • importance of ethnic identity? • definitions of health and disease? • family dynamics? • understanding of spirituality?
Personal Practices: How do I address clients? How respectful am I of the client's physical and psychological boundaries? How does my sense of appropriate intervention vary from the client's? How does prejudice affect my judgments of clients?

The atmosphere of the information center was designed with the assumption that artwork by gay artists and flyers and brochures targeting the gay community would make the patrons feel comfortable and accepted. This effort was in fact successful, at least for white gay and bisexual men. However, the agency ignored the cultural reality that *many African-American gay and bisexual men who consistently have sex with men may not identify themselves as being gay.* Thus brochures titled "What Gay Men Need to Know about HIV" may be unappealing to them. Further, while the center was adorned with gay imagery, since no African-Americans were included, African-American patrons experienced the center as unreflective of them and their reality.

The motivational technique (i.e., discussing the social and community impact of HlV) may be less effective for African-Americans also. Why? *Many gay African-Americans do not see the "gay community" as their community.* In addition, the personal style encouraged among center staff, which is grounded in an effort to assume a posture of friendly familiarity with the patrons, might be less effective for African-American clients. Why? *Many African-Americans prefer to be addressed with an honorific title,* especially by whites whom they do not know personally. In addition, the approach of encouraging the frank revelation of sexual history on a survey ignores the fact that *many African-Americans do not like to reveal personal information to people or organizations with whom they are not familiar.* Lastly, a referral strategy that promoted safer sex parties and support groups may be less appealing for African-Americans because *many African-Americans feel disinclined to reveal intimate aspects of themselves to whites they do not know.*

Without substantial familiarity with African-American culture and people or accessible expertise about this group, the designers of the public health intervention could not predict diminished effectiveness for the very population they had decided to target. Yet their lack of knowledge of the cultural realities cited above critically undermined the success of each component of the HIV prevention campaign.

Additional Concerns

The approach to operationalizing competency presented here is based on articulating the generalizations that are relevant to the organizational activity being analyzed. The challenge for any organization contemplating cultural competency is two-fold. First, it must tap into cultural informants whose experience allows them to know these generalizations.

Second, the organization must train its staff to use such expertise to search for the relevant cultural generalizations but not turn them into stereotypes. Clearly, there is tremendous variation between different people of the same ethnicity, and people within ethnic groups vary with respect to many factors, such as region, income level, and most importantly, individual

history. The organization must be careful not to turn a useful generalization into a categorization that makes it difficult for the staff to accept the tremendous individual variation within any group. Even if a generalization is true 80% of the time (which is rarely the case), the other 20% of the time people should not have to fight with the organization to be treated as unique individuals.

In order to sustain cultural competency, an organization should keep three factors in mind. Initially, it must work towards hiring staff of the same ethnic background as the client population. Not only are such staff essential to helping clients feel more comfortable, but their presence often serves as an important reminder of the continued need to grapple with the implications of cultural differences within the agency setting.

Additionally, the organization should, over time, come to a reasonable degree of consensus regarding such difficult issues as the role of racism in clients' lives, problems arising from too much color blindness, problems arising from too much stereotyping, and the relationship between client culture and service efficacy. This can only take place if management makes an effort to ensure that people feel safe in discussing ethnic, racial, and cultural differences. Annually scheduled diversity trainings usually do not achieve this result.

Finally, people of color must be in positions to influence intervention design either as managers or as members of a standing committee empowered to influence agency policy. This suggestion is based on the recognition that unless organizations *institutionalize* their commitment to cultural competency, they will tend to drift away from it.

Summary

It is the hope of the authors that this discussion of the complex nature of assessing and implementing organizational cultural competency has been instructive for our readers. A realistic look at the expectations for population change in the United States, as well as the increased tendency of groups to define and redefine themselves as distinct and special communities, cannot help but affect service program philosophy, treatment provision, and hiring and training practices. The concerted effort on the part of service agencies to anticipate and respond positively to these cultural shifts will greatly affect their ability to provide services that are relevant to their clients, meaningful to their communities, and most importantly, effective in meeting their mandate to facilitate client change. By grappling with issues of how culture should affect organizational activities, these agencies are effectively participating in the ongoing national discussion about cultural competency, and about multiculturalism in general. This is undoubtedly positive, because providers bring to these debates their experience in empowering people who, for a variety of reasons, deserve assistance so that they can most effectively participate in this debate. It is

essential that agencies approach these issues in a manner that honors their clients, projects a clear theoretical perspective, and ultimately, contributes to the understanding of the multicultural fabric of the United States.

References

Cross, T.L., Bazron, B.J., Dennis, K.W., and Isaacs, M.R. (1989). Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed. Washington, DC: Child and Adolescent Service System Program Technical Assistance Center, Georgetown University Child Development Center.

Chapter 2

CULTURAL IDENTITY AS AN INDICATOR OF RECOVERY FROM SUBSTANCE ABUSE: AFRICAN-AMERICAN WOMEN'S PERSPECTIVES

Judith Jones, PhD, Frances Hutchins, Cynthia Childress, RN, PHN, Bonnie Buntz, MA

Office of Substance Abuse
San Joaquin County, California

Introduction

African-American women are "like all other women, like some other women and like no other women" (Berg & Jaya, 1993). While they may resemble each other in some ways, they are also products of their own distinct families, subcultures, and histories. In spite of the danger of overgeneralization, African-American women substance abusers, speaking from their individual perspectives, can provide valuable insights into what has helped them during the recovery process and what has been a barrier to recovery. From these singular perspectives, common threads may emerge. This chapter focuses on African-American clients' perceptions of themselves as part of a community of African-Americans as well as their links to "cultural identity" as a factor in recovery from substance abuse treatment.

The chapter explores the hypothesis that African-American women clients who both recognize and feel links to their "cultural identity" are more successful in maintaining sobriety after successful completion of substance abuse treatment programs than women without those links. The chapter is intended for staff who work with substance abusing women in a variety of contexts.

Throughout this chapter the term "cultural identity" is defined as a sense of connectedness to specific people, rituals, customs, and institutions with which one feels some kinship and sense of shared history.

To gather the material for this chapter, a trained African-American interviewer conducted interviews using a series of structured questions. The questions explored connections with family/ extended family; neighborhood; religion and culture; African-American institutions; and other networks of support. The interviews were conducted with a total of fourteen women. Seven were successful in maintaining sobriety for six months or more following completion of their treatment program; the other seven were not.

The perceptions of African-American women in recovery vis-a-vis the importance of cultural identity, as well as the actual links that these women have forged, may have important implications for the structure and organization of women's treatment programs. If, for example, clients who perceived that they had ties to their cultural identity and could identify a number of those links were more successful in recovery than those without the same sense of connectedness to individuals, family, neighborhood, religious rituals and culture, then programs may be able to make adjustments to help strengthen those connections.

Information about "cultural identity" and "cultural diversity" issues gleaned from clients can increase the understanding of the various factors that contribute to both short- and long-term sobriety. Client perspectives can also help guide practitioners in future program design, including the intake/assessment process and aftercare programs.

Review of the Literature and Discussion of Confounding Factors

Recognizing cultural variables and cultural identity issues in the treatment of substance abusers and in therapeutic contexts has taken on increasing importance in recent years. Nevertheless, this issue is not a new one, particularly in the counseling context.

In 1971, Jackson attempted to explore the relationship between racial self-designation and preference for counselor (Jackson, & Kirschner, 1973). His study, which focused on over 391 Black students at a predominantly Black urban county college, indicated that students who referred to themselves as Black or African-American preferred a counselor of African-American descent to a greater extent than did those students who regarded themselves as Negro. He concluded that investigators and professional helpers alike must take into account the client's racial self-designation as an important component of a client's frame of reference and, ultimately, in the delivery of client services. In a later work, Sue identified a spectrum of cultural and historical perspectives relevant to African-American, Latina, and American Indians in counseling settings (Sue, 1981). A number of studies have focused on the effects of race on counseling outcomes of African-American patients, thus far with inconclusive results. Atkinson, for example, conducted a review of the research on effects of race on counseling outcomes. His conclusion was: "rather consistent evidence that Black subjects prefer Black counselors" (Atkinson, 1983). He cautions, however, that "the lack of replication with other groups sampled (American Indians and Latina) and evidence of within-group differences for Blacks suggest that preference for an ethically similar counselor is not universal." In a very recent study "written for non-Asian family therapists who must deal with an increasing number of Asian-American client families", the authors generalize to other groups, contending that most ethnic minority clients want to cooperate with professionals, no matter what their ethnic origin (Berg & Jaya, 1993).

In recent years, research and practice has focused on African-American clients, particularly in counseling settings. At the same time, ethnic/racial issues in substance abuse treatment have received significantly less attention. Nevertheless, the few studies that have been done in this area

provide some direction for culturally competent practice. Longshore, Hsieh, and Anglin (1993), for example, explore ethnic and gender differences in drug users' perceived need for treatment, and recommend that "special emphasis be placed on the engagement of African-American and Latina clients at each step of the treatment."

There is almost no literature on the relationship between the African-American woman substance abuser, the African-American community and society at large nor on the effect that this relationship may have on treatment outcomes. Nevertheless, studies that have focused on other issues appear pertinent to the subject of African-American women substance abusers. Walker and Small in their study titled *"AIDS, Crack, Poverty and Race in the African-American Community: The Need for an Ecosystemic Approach,"* make a strong case for the development of ecosystemic health care intervention programs, "which locate the illness within the larger context of family, community and political system." In particular, ecosystemic programs should be able to provide "techniques for mobilizing the resources of social networks and extended kin systems to be caregivers and problem solvers" (Walker & Small, 1991). Walker and Small also discuss the powerful effects of racism on individuals, which has dire consequences in terms of individuals' sense of self-esteem, their perceptions of their place in the community, and their sense of belonging to and identifying with a particular community. (Walker & Small, 1991).

Although the literature written thus far on minority issues, women's issues, and substance abuse issues sheds some light on appropriate approaches to engaging clients, providing effective counseling services, and placing African-American issues in a broader ecosystemic context, more information is needed. In particular, a focus on the client's point of view will help determine whether there are consistent and recurring themes regarding cultural identity and cultural sensitivity issues and if they affect both treatment and recovery outcomes.

One thing is clear. Cultural identity and cultural sensitivity issues are complex and cannot be isolated from other factors that may either draw a woman of color into treatment or cause her to leave treatment. A myriad of external factors may play a role, including legal sanctions, custody challenges, class/economic issues, pregnancy status, relationships with significant others, and contacts with other women enrolled in the program. To further confuse the matter, the relative importance of each factor may change at the conclusion of treatment and jeopardize sustained recovery.

While these are only a few of the confounding factors with which we are faced, we believe that clients can help us understand cultural issues in the context of recovery and that beyond the differences, some common themes may help us design programs that are truly responsive to cultural identity and cultural sensitivity issues.

Methodology

Fourteen interviews were conducted over a six-week period. Seven of the interviews were with African-American women from the AIM program, a grant-funded Center for Substance Abuse

Program (CSAP) project for pregnant substance abusing women and their children up to five years of age. The other seven were with African-American women from FOCUS, an Abandoned Infants Assistance (AIA) grant-funded program for post-partum women substance abusers and their children up to five years of age. All of the women had completed the program (9 months at FOCUS and up to 9 months at AIM) and were either participating in a weekly Aftercare Component or had completed all program segments. Seven of the women had been successful in maintaining sobriety for six months or more following completion of the program, whereas the other seven had not been successful during the same period.

All of the women were in their twenties and thirties, the mean age of the participants was 29. The women each had from one to six children, with seven having 1 to 3 children and the other seven having 4 to 6 children. All were single at the time of the interview; one was living with a significant other. Ten of the women had been in one other substance abuse program prior to entering either FOCUS or AIM, two had been in two programs prior to entering FOCUS or AIM, and two did not answer the question on prior program involvement.

The interviews were conducted by an African-American interviewer from another county health program. She was selected because she would be seen as a neutral party not connected to substance abusing or child protective service programs, she had extensive experience working with both pregnant and post-partum African-American women, and she had a particular interest in and sensitivity to substance abusing women. She was also familiar with the neighborhoods in which many of the interview participants lived and had many contacts within those neighborhoods because of her outreach work. She had conducted interviews with potential clients for another program and had a low-key but very supportive manner. Prior to conducting the interviews, both she and another African-American staff person from a county health program met with the authors, reviewed all of the questions, and suggested changes to simplify the language or to make the questions flow more easily. Changes were made both in the language and in the format used for eliciting information.

The interviewer contacted the clients either by phone or in person (in cases in which the client did not have a phone). She then met with the clients at a location agreeable to them and, using an open ended interview style, asked each client a series of questions. The questions included queries regarding the age, sex, race, marital status, and living situation of the clients. After this background information was gathered, the questions focused on links to family and community including: connections with extended family; connections with neighborhood; connections with religion and culture; interpersonal relationships; links to users of drugs and alcohol; and other networks of support. Finally, a series of questions focused on substance abuse treatment programs, including questions about program preferences, counselor preferences and one final question that directly asked the client to consider whether she would prefer a program in which more of the staff members were Black. All of the interviews were taped and transcribed so that they could be carefully reviewed. A token of appreciation was given to participants for sharing their time and experience.

Discussion

The hypothesis that was explored was that African-American women clients who both recognized and felt links to their cultural identity were more likely to be successful in maintaining sobriety after successful completion of substance abuse treatment programs than women without those links. The important cultural identity links to consider include a sense of connectedness to specific people, rituals, customs, and institutions with which one feels some kinship and sense of shared history.

Although it is difficult to generalize based on the small number of interviewees, several differences emerged between the two groups regarding connections with family and groups. Those women who maintained sobriety were more likely to be able to identify a person helpful to their recovery than those women who had relapsed, and in the majority of cases the person identified as particularly helpful was African-American. Interestingly enough, all but one of the women who identified a person who had been particularly helpful to her in her recovery named a family member, specifically a mother or father.

On the other hand, those women who relapsed following program participation were more likely to have family members who used drugs. They also had more difficulty identifying persons helpful to their recovery, persons who would help them with a problem, and/or groups that would provide support.

Interviewee Responses to Questions

Ties to Individuals, Family, Groups	Women Maintaining Sobriety (n=7) Yes*	Women who Relapsed (n=7) Yes*
A person especially helpful in recovery: Is this person Black?	6 (86%)	4 (57%)
A group especially helpful in recovery: Is the group Black?	7 (100%)	5 (71%)
Family members who use drugs?	2 (29%)	5 (71%)
Able to identify people not supportive of the recovery process?	3 (43%)	1 (14%)

*** NOTE: Not all questions were answered by all of the women (total number of women interviewed=14)**

The women who maintained sobriety were more likely to be involved in Narcotics Anonymous/Alcoholics Anonymous (50%) than those who relapsed (25%). Although NA/AA provide a community of support, the groups are diverse and include both men and women and individuals from all ethnic and racial groups. It is not clear that they provide the ties to cultural identity explored here. Those women who maintained sobriety were also more able to identify individuals not supportive of them during recovery. Is it perhaps because they had achieved a greater awareness of both what they needed and what was detrimental to them?

Few differences emerged between the two groups with respect to connections with neighborhood and connections with religion and culture. Most clients described their early years and their neighborhoods as predominantly Black (10) and the majority indicated that they still lived in predominantly Black neighborhoods (8).

Most described themselves as Christian (11) and most indicated that they read or studied the Bible, but there were no clear distinctions regarding religion between those who had maintained sobriety and those who had not. Most indicated that they attended Black entertainment programs including movies and that they listened to music by Black musicians, but again, there were few distinctions between the two groups.

As far as interpersonal relationships with members of the same race, no significant differences emerged between the two groups. Most of the women indicated that they did not associate mostly with Black people. In fact, all but two indicated that they associated with people from various ethnic and racial groups. It is not clear, however, whether the choice of associations demonstrates a personal preference or is simply a reflection of the greater community. Stockton, the city where all of the clients reside, is a highly diverse community; moreover, the programs in which these women have been involved are comprised of women of all ethnic and racial groups. Since many women do develop friendships through the program, this response may also reflect the composition of the programs and the women's ability to relate to others in a bicultural context. Bicultural is defined here as "the holding of values from and ability to function in two worlds" (Ziter, 1987).

In an attempt to explore "best practices," the interviewer asked several questions about substance abuse treatment programs. Answers to one question in particular may reflect cultural identity issues. Of clients who answered the question, five of those who relapsed were more likely to prefer a program where more of the staff were Black. Only two of those who maintained sobriety preferred a largely Black staff.

When comparing the two groups, it is worth noting that clients who maintained sobriety were able to identify individuals in their lives who provided support in recovery. In most instances, this person was African-American and a family member, suggesting that family members who were not users provided an important link to recovery. Counselors and groups like Narcotics Anonymous and Alcoholics Anonymous were also identified as important sources of support.

Where links to family were weak and/or family members were users, the importance of being able to identify with an African-American counselor seemed more important to clients. It is possible that women who relapsed may have perceived that their connection to a Black counselor was more important to them in their recovery because they were able to identify with the counselor immediately based on common culture, backgrounds and experiences. It is also possible that women who did not feel linked to staff and did not have other networks of support found it more difficult to maintain sobriety than those who did.

Although no clear cut answers emerge from these fourteen interviews about the importance of cultural identity issues in recovery, it is important to listen to what the women themselves had to say. In their responses to questions, they shed light on their own struggles, articulate what it means to be poor and Black, and reflect broader societal concerns about cultural identity issues. One woman, for example, when asked about which counselors she relates to best and about those whom she can turn to for help, explains that:

> *It depends on what the problem is. I may go to a Mexican counselor. It depends on what they've been through. They have to relate to what I'm saying.*

Yet the same woman expresses a preference for a Black counselor, when given a choice:

> *...It would look good. It would look good because I see some Black counselors, I look up to them. Because it's so positive you know. You know, you step out and you see the ones that are on the street. I feel bad for my sisters or brothers, it's all I could do is just pray for them. It would look real good for Black people to get the education that they need to get jobs and get off the streets because a lot of them are dying or a lot of them are going to jail. I like to see the ones that are really positive and getting themselves a good life. It looks good, it really does.*

On the one hand, the client understands that her own needs vary and that her choice of counselor depends on her particular needs at a given moment in time. On the other hand, she recognizes the lack of opportunities afforded to many African-Americans, and sees Black counselors as being able to serve as role models for other African-Americans. Finally, she extends the role of the counselor into an economic context in which the counselor represents a stepping stone out of unemployment, incarceration, and violence.

A similar ambivalence is expressed by another woman interviewed. In response to a question about whether she visits her old neighborhood, she says:

> *No...For me that's like slippery places. Okay, it's very tempting. For me to go back to that same crowd of people I would get tempted easily because they are using.*

The same client expresses a preference for living in a mixed neighborhood:

> *(I don't live in a Black neighborhood now.) It's a mixture of everybody here. I relate better you know, to a mixture even though I was raised in an all Black neighborhood.*

This comment may also reflect what writers such as Walker and Small (1991) describe as the "victory of disorganization and the loss of structural controls provided by family, neighborhood and religion. For African-Americans, these losses were very great indeed. Family, extended kin, religion and community had been the very instruments through which hope had been preserved during centuries of oppression the structures which fostered survival, connectedness and meaning. Assaulted by the stress of urban poverty without structures which offered alternative visions, families of the inner city increasingly fell prey to alcoholism, drugs, violence between man and woman and parent and child, and the random violence within the community" (Walker & Small, 1991). And, yet, when asked whether she would prefer a program in which more of the staff were Black, the same woman answers:

> *I think so, because for one, the Black counselor understands anger better than the white counselors. Some of the white counselors don't relate (to) how we get angry.*

The client appears split between her belief that she relates better to a mixture of people and her feeling that counselors of different racial and ethnic groups do not understand the way she expresses anger. Although it is true that the role of counselor is not the same as that of a neighbor or community member, the client does seem to recognize that emotions, such as anger, may be expressed differently by members of different racial and ethnic groups.

A third client presents still another view when asked whether she would prefer to be in a program where more of the staff were Black:

> *No! I don't know...I look at it in two different (ways). If I could be in a program with all Black, I am sure I would learn a lot about Black issues. A lot of things I need to know about (being) a Black woman. But, then, on the other hand, I look at it as life is not all Black....that if I don't be around other people that I might tend to carry a grudge or I may tend to not even want to go to work because there is white people or there is Mexican people. I got to learn how to better communicate with all kinds of people. So, it is giving me a chance to be able to learn another person. Look at them as people, not the color.*

In this final commentary, the interviewee offers a perspective on the dilemma that she, and for that matter most African-American women, face. Her comments reflect her recognition of her connection to other African-American women, or in other words, her cultural identity. She is aware of the history she can draw upon through a shared experience with her African-American sisters and the value that would be derived from learning more about Black issues. Nevertheless, the client is conflicted. At the center of her conflict is the knowledge that she is an African-

American woman living in a very diverse environment. She recognizes that her future depends upon her ability to communicate with "all kinds of people." Although she does not say so directly, the client then intimates that the world she lives in is, in fact, not a Black world but a society in which she must maneuver around sexist and racist barriers to achieve her goals.

Despite the various differences that exist between the group of women who maintained sobriety and those who did not, all of them express a great deal of ambivalence. They find it difficult to reconcile the role played by individuals, family members, and groups who have assisted in their recovery and the role of African-American staff in programs. They are also conflicted about the importance of African-Americans in their recovery, even though in cases in which family members are not using drugs, mothers, fathers, and siblings have been instrumental in providing support for recovery. Perhaps this ambivalence reflects the conflict they feel about being African-American women in a society in which the dominant values are those of white males.

What lessons, if any, can be extracted from these interviews? And how can they serve us in the design of future programs? The interviews do seem to support the importance of links between clients and family members in recovery. In cases in which family members are themselves abusers, African-American role models and mentors are a critical element, and the women who relapse during recovery need more African-American staff members in programs. This clearly means that there is a need for at least some African-American staff members in programs in which African-American women are involved.

Equally important is the need for a sensitive and responsive staff, a staff that understands the importance of different forms of anger and different types of communication. In order to understand and respond appropriately to cultural differences, all staff need training in cultural competency, focusing on such issues as: the historical impact of racism and sexism; the development and maintenance of relationships, communication styles, historical traditions, and customs; and the rich role of family, extended family and religion in the culture.

Finally, the interviewees' perceptions of the importance of cultural identity issues in recovery have implications for the individual intake and assessment process. In such an intake assessment process, questions would incorporate the notion of "links to cultural identity". In cases in which a client's links to family, extended family, groups, and religious and cultural institutions were identified as weak, the treatment plan developed between the client and her case manager could incorporate a strong "cultural identity" component. On the other hand, an intake and assessment process which identified strong links to non-using family members and extended family, could build a treatment plan that would emphasize those connections.

Similarly, design of an Aftercare Plan would take into account the client's links to culture and strong and positive family relationships, as well as family connections which might undermine the recovery process. An Aftercare Component for women with substance abusing family members, for example, might link the woman to a non-using female mentor with a similar history and shared

values. An Aftercare Component for women with supportive, non-using family members and strong ties to their communities might instead develop a plan that emphasized those relationships and community ties.

These few voices draw together some common themes important to the recovery process for African-American women: the need for links to others; the need for nurturing and support from non-using family members or counselors; and the need for links to groups that can provide reinforcement for maintaining sobriety. Equally important is a theme expressed in the ambivalence of a number of women -- coming to terms with what it means to be an African-American woman in a highly diverse community in which the effects of sexism and racism have yet to be overcome. We continue to believe that by listening to African-American women themselves we can better shape programs that speak to the individual and the cultural differences relevant to recovery.

References

Atkinson, D.R. (1983). Ethnic similarity in counseling psychology: A review of research, The Counseling Psychologist, 11, 79-92.

Atkinson, D.R., Morten, G., & Sue, D.W. (1983). Counseling American minorities: A cross-cultural perspective (2nd ed.). Dubuque: Brown .

Berg, I.K., & Jaya, A. (1993). Different and same: Family therapy with Asian-American Families, Journal of Marital and Family Therapy, 19(1), 31-38.

Brisbane, F. L. & Womble, M. (1992). Working with African-Americans, The Professionals Handbook. Chicago: HRDI International Press.

Bry, B. (1983). Substance abuse in women: Etiology and prevention. Issues in Mental Health Nursing, 5, 253-272.

Burman, S. (1992). A Model for women's alcohol/drug treatment, Alcoholism Treatment Quarterly, 9, 87-99.

Copeland, J., & Hall, W. (1993). A comparison of a specialist women's alcohol and other drug treatment service with two traditional mixed sex services: Client characteristics and treatment outcome. Drug & Alcohol Dependence, 32, 81-92.

Hanson, M., Lynch, E., & Wayman, K.I. (1990). Honoring the cultural diversity of families when gathering data, Topics in Early Childhoood Special Education, 10(n1), 112-131.

Harrison, P. (1989). Women in treatment: Changing over time, International Journal of the Addictions, 24(7), 35-44.

Hurdle, D.E. (1990). The Ethnic Group Experience, Social Work with Groups, 13(4), 59-69.

Jackson, G,. & Kirschner, S.A. (1973). Racial self-designation and personal preference for a counselor, Journal of Counseling Psychology, 20, 560-564.

Lassiter, S. M. (1994). Black is a color, not a culture, implications for health care, The ABNF Journal, V(1), 4-9.

Longshore, D., Hsieh, S.C., & Anglin, M. D. (1993). Ethnic and gender differences in drug user's perceived need for treatment, International Journal of the Addictions, 28, 539-558.

Meadows, J.L. (1991). Multicultural communications. Physical and Occupational Therapy in Pediatrics, 11(4), 31-42.

Midgley, J. (1991). Social development and multicultural social work. Journal of Multicultural Social Work, 1(1), 85-100.

Nichols, M. (1985). Theoretical concerns in the clinical treatment of substance-abusing women: A feminist analysis, Alcoholism Treatment Quarterly, 2, 79- 90.

Parham, T.A., & Helms, J.E. (1981). The influence of black students' racial identity attitudes on preferences for counselors' race. Journal of Counseling Psychology, 28, 250-257.

Pedersen, P.B., Draguns, J.G., Lonner, W.J., & Trimble, J. (Eds.). (1981). Counseling Across Cultures (rev. ed). Honolulu: University Of Hawaii Press.

Perez-Arce, P., Carr, K.D., & Sorensen, J.L. (1993). Cultural issues in an outpatient program for stimulant abusers, Journal of Psychoactive Drugs, 25(1), 35-44.

Robinson, J.B. (1989). Clinical treatment of black families: issues and strategies. Social Work, 34(4), 323-29.

Ruiz, A. S. (1990). Ethnic identity: Crisis and resolution. Journal of Multicultural Counseling and Development, 18, 33-40.

Sue, D.W (1981). Counseling the Culturally Different: Theory and Practice. New York: John Wiley.

Thomas, L.E. (1993). What Motivates FOCUS Program Participants to Complete the Program?. Unpublished Master's Thesis, California State University School of Social Work (Sacramento).

Walker, G., & Small, S. (1991). AIDS, crack, poverty and race in the African-American community: The need for an ecosystemic approach. Journal of Independent Social Work, 5, 69-91.

Westermeyer, J. (1989). Non-treatment factors affecting treatment outcome in substance Abuse. American Journal of Drug and Alcohol Abuse, 15(1), 13-29.

Ziter, M. (1987). Culturally sensitive treatment of black alcoholic families, Social Work, 32(2), 130-135.

Chapter 3

OBSTACLES TO CULTURALLY SENSITIVE SERVICES FOR DRUG-ADDICTED WOMEN AND THEIR CHILDREN

Terry Wright, MSW, Kim Donoghue, MSW

Parents and Children Together (P.A.C.T.) Program
Children's Hospital
Buffalo, New York

Introduction

Culturally sensitive social service practice is believed to increase mutual communication, utilization of services, compliance, treatment effectiveness, and consumer satisfaction (Inclan & Hernandez, 1992; Kavanagh & Kennedy, 1992; PolitiZiter, 1987). All of these issues are extremely important in work with drug-addicted women and their children. Because the health and safety of drug-exposed children are at risk, it is extremely important to engage their mothers in services to ameliorate any biological effects and to prevent abuse and neglect, which is more prevalent among substance abusing parents than among other parents (Black & Mayer, 1980).

Women who are identified as substance users/abusers through the birth of a drug-exposed child are judged very harshly by health and human service providers and by society in general (Gustavsson, 1991). The treatment women receive is often so abrasive and blaming that it reinforces their distrust in service providers and decreases their willingness to utilize services, especially once those services are no longer mandated by child protective agencies.

Even though substance abuse among women of childbearing age is widespread (Chasnoff, 1990; National Institute on Drug Abuse, 1989), most of the women who are identified as substance abusers are poor minority women (Feig, 1990; Gustavsson, 1991). This suggests that there are few middle- and upper-class white women identified, so that the majority of women served by alcohol and drug addiction treatment programs are economically disadvantaged minorities. Therefore, in order to serve this population effectively, traditional paradigms of treatment, based on models developed for middle-class white males must be revised, and programs must train their staff to be sensitive to ethnic differences as well as to the special issues women face as they struggle with substance abuse, poverty, and parenting.

Much of the literature has been devoted to looking at the obstacles ethnic minorities face when utilizing health and human services such as distrust of services, differing values and beliefs, language barriers, and differential access to services. The reader is cautioned about broad generalizations regarding members of any ethnic/racial group, due to the tendency to obscure important differences across individuals and subgroups within groups.

This chapter will briefly review why it is important for service providers to be aware of ethnic differences, barriers to cultural sensitivity in the provision of services, and recommendations for overcoming those barriers. Using the Parents and Children Together (P.A.C.T.) program as the social service agency case in point, we will then focus more specifically on the obstacles faced by drug-addicted mothers. Through case example, we will illustrate how inattention, avoidance, denial, and in some cases, outright hostility towards differences, interferes with the provision of effective services. Finally, we will show, again through case example, how culturally sensitive services can effectively engage and retain drug-addicted women and their children, thereby increasing the quality of life of both mother and child.

The P.A.C.T. Program

The Parents and Children Together (P.A.C.T.) program provides comprehensive medical, developmental, and social services to children prenatally exposed to cocaine and to children infected with and/or affected by HIV. It is the P.A.C.T. program's goal to either provide, arrange for, or help the client families locate and access the services they need to lead satisfying and productive lives. As it is not possible to provide all of the services that families need; coordination and follow-up among service providers is an ongoing priority of the P.A.C.T. program staff.

The P.A.C.T. program believes that in order to ensure a holistic approach to serving children and families with special needs, a multidisciplinary approach is needed. The P.A.C.T. program is staffed by physicians, nurse practitioners, nurses, social workers, case managers, a parent-child educator, 5 maternal-infant specialists (lay home visitors who provide support, friendship,and linkage to community-based services).

The P.A.C.T. program strives to provide quality medical and psycho-social services while recognizing that individual family members have their own values, beliefs, and coping styles. The program values family autonomy and works with the family members to determine the level of professional support needed to enable them to nurture and care for their children. The goal of the program is to strengthen family cohesion and enhance parental self-esteem and parenting skills.

The scope of services includes child health supervision, providing both primary and acute illness care, ongoing intensive social work services, and developmental and nutritional screening. These services are provided to children from newborn to age 12.

The P.A.C.T. program has been in existence for almost seven years serving women and children primarily from African-American and Latino groups. Therefore, the literature review and case studies are geared toward these populations. The chapter will attempt to answer the following questions: Why do we need culturally sensitive services? What are the barriers to cultural sensitivity? What are recommendations for overcoming obstacles when working with ethnic minorities in general, and more specifically, with African-Americans and Latinos?

Rationale for Cultural Sensitivity

Perhaps the most important reason to provide culturally sensitive services is that effective medical and psycho-social care cannot be rendered if clients mistrust or disagree with the service providers. Tharp (1991) suggests that the culturally sensitive worker and the client's cultural experiences together create the ambiance that is necessary to establish rapport and an empathic bond which facilitates the therapeutic process. However, the opposite tends to occur as cultural differences are often trivialized by providers (Bennett, 1986). Politziter (1987) suggests that this triviality causes African-American families to leave treatment prematurely or fail in achieving the goals of treatment. He argues that the effective treatment of African-American alcoholic families, especially by white practitioners, requires culturally sensitive practice.

In an article more applicable to the work of the P.A.C.T. program, Devore and Schlesinger (1986) state that the ethnically sensitive worker must be knowledgeable about the diverse responses to illness across cultures and ethnicities, and call upon community-based caring networks to generate a more humane health care environment. The P.A.C.T. program purposely employs outreach workers who reflect the ethnic backgrounds of the clinic populations and who reside in the same neighborhoods. They understand how clients may react to services, and because they are actually a part of the community, can facilitate the use of a community support network. Inclan and Hernandez (1992) also suggest that therapists must be attuned to class and cultural nuances. They state that including values, beliefs, and cultural narratives in the therapeutic process allows for a degree of cultural specificity that can increase the effectiveness of treatment with Hispanics/Latinos, the poor, and other minorities.

Barriers to Cultural Sensitivity

Despite the theories which exist regarding cultural sensitivity, in actual practice, barriers exist which prevent the implementation of culturally sensitive practice. Institutionalized racism supports prejudice and discrimination (Brill, 1985) creating a situation where even among social workers there is a lack of commitment and insufficient information regarding how to work effectively with specific ethnic groups. The knowledge available is focused largely on issues of direct practice, leaving underdeveloped the theories surrounding planning, organization, and administration of human service programs as they relate to multiculturalism.

Stevenson, Cheung & Leung (1992) believe that all workers must confront not only deficits in their knowledge and skill about ethnic differences, but also their attitudinal biases, which may be inadvertently reinforced by the nature of their work and sometimes even by training efforts themselves. Service providers may judge their clients' attitudes and behaviors based on their own personal value systems (Brill, 1985). The following case study illustrates this barrier to cultural sensitivity:

> A Latina mother of two would always come to clinic with her husband. Decisions were not made until she consulted with her husband. Some of our clinicians believed that the husband was physically abusive toward the mother. This view was based on the fact that the mother would always look at her husband before responding to questions posed by the staff. In some instances, this is a behavior characteristic of domestic violence. However, employees never witnessed any physical signs of abuse in the clinic setting or during unannounced home visits. It was not until the staff learned more about the Latino culture that they began to accept the above mentioned behaviors as culturally correct and not harmful.

Along with personal biases, medical staff tend to allow their professional biases to color their treatment. Devore and Schlesinger (1986) suggest that the American health care system pays little attention to beliefs derived from a client's ethnic background. Health care practitioners will focus on the diseased organ, having neither the training nor the time to look beyond that organ at the person suffering from the disease.

Developing Cultural Sensitivity

While obstacles to cultural sensitivity are deeply ingrained in society, there are techniques that can be used to overcome them. The following recommendations apply to all ethnic groups, and they should be considered the basis for obtaining cultural sensitivity.

The first recommendation addresses the issue that a provider's values and beliefs can be barriers to cultural sensitivity. Brill (1985) suggests that providers can begin to overcome this barrier by accepting their own strengths and limitations. Self understanding on the part of the practitioner is an important first step to culturally sensitive practice. Then, practitioners can strive to develop a self-awareness that will enable them to understand and, if possible, change attitudes and feelings and control their behavior in working relationships.

Stevenson, Cheung & Leung (1992) suggest that practitioners need to be aware of their own cultural limitations, open to cultural differences, utilize cultural resources, and respect the uniqueness of clients' ethnographic characteristics. Stevenson also offers some questions for practitioners to ask themselves, such as: What does a hand shake convey? What do I assume regarding my client's perceptions about time and personal space? How might ethnicity (mine or the client's) influence the way each of us defines the problem?

After learning to deal with their own values and beliefs, workers can move the focus to the values and beliefs of others. For example, workers can learn about another by frequenting traditional ethnic restaurants, visiting ethnic stores, or attending cultural festivals. A one-to-one exchange of ideas with another individual from another culture can also greatly enhance the learning experience. Brill, (1985) suggests that workers should be open to considering new ideas and approaches and be committed to ongoing learning.

On a system level, Stevenson, Cheung & Leung (1992) stress the importance to culturally sensitive practice of knowing the greater implications of a client's ethnic background and working with both micro and macro systems that affect client functioning. Effective programs in inner city communities should be community-based, family-oriented, and multi-generational. These systems traditionally provide critical cultural support, such as in the African-American and Hispanic/Latino cultures. Services should be coordinated by one family case manager who understands institutional racism and oppression and the related policies that create environments for problems such as AIDS and the use of crack cocaine which proliferate in impoverished minority communities due to the lack of education and effective programs of prevention and intervention (Walker & Small, 1991).

Change in the policy of hiring employees is also needed. Devore and Schlesinger (1986) suggest increasing the number of health and human service providers who are members of ethnic minority groups. However, even if the client and practitioner are of the same race, the practitioner should assume that his/her experiences with racism may differ significantly from the experiences of the client (Robinson, 1989). The following case study illustrates a situation in which the worker did experience the same obstacles as a client:

> An African-American clinician visited an expectant mother, who was from the same ethnic background, in her hospital room. The mother's nurse, a white woman, interrupted the visit by screaming at the clinician that family members were not allowed to visit during that time of day. Even though the clinician had on an identification badge in clear view, the nurse seemed to focus only on the color of the clinician. She assumed that the clinician was a family member and treated her poorly. What kind of message was being sent to the expectant mother when another professional was treated in that manner?

By following the general guidelines, workers can achieve culturally sensitive practices. However, different approaches should be used with specific minority groups.

African-American clients should be approached in a down-to-earth, egalitarian manner that reduces the difference in status between the client and practitioner (Tharp, 1991). This could be accomplished by having the practitioner form a partnership with the client rather than be perceived as a powerful authority figure (Politziter, 1987). It is also important to allow the

family to assess the practitioner in order to check for any potential bias. Politziter also believes that through personal relationships with African-Americans, the white practitioner can learn to appreciate their history. This appreciation can not only create a better client-practitioner relationship, but can also increase understanding and alleviate racism in general. The next vignette will demonstrate how the P.A.C.T. program implemented this concept:

A 28-year-old African-American mother brought her daughter to clinic for a follow-up, emergency room visit. This mother expressed her frustration with one of the hospital's x- ray technicians. She complained that the technician first assisted a Caucasian child, skipping over her child. The mother labeled the situation as racist in nature. Even though the Caucasian child may have required more immediate medical attention, the mother did not perceive the situation in that way. Our clinical staff did not try to defend themselves on the behalf of the technician. This type of response would only have added to the mother's anger. The clinic staff treated the situation as an opportunity to learn about this minority woman's experience with negotiating in a majority-influenced health care setting. Apparently, this African-American woman distrusts the predominately white health care field. To this day, we continue to focus on building trust with this client.

Tharp (1991) states that the most effective therapeutic treatment with poor African-Americans has been home visiting programs aimed at supporting and counseling mothers of young children. Child language development and mother's teaching styles are of particular interest in mother-child treatment programs. The P.A.C.T. program is designed to offer services within the home environment. Nurses, social workers, case managers, and maternal-infant specialists all make home visits. Potential behavioral concerns can be observed in the environment in which they occur and can be addressed immediately. The child's anxiety, as well as the parent's, is lowered as people tend to be more comfortable in their own surroundings. Information is not as easily forgotten since it is not being transferred from one setting to another. These are only a few recommendations specific to the African-American client population. It would be a great stride toward cultural sensitivity if professionals could incorporate these few suggestions into their practice. This is also true for the following recommendations for work with Latinos.

Inclan & Hernandez (1992) recommend four phases of culturally sensitive treatment for Latino substance abusers: cultural migration (learning about the family's history, values, and heritage); exploration and redefinition of substance abuse problems in a cultural framework; intervention; and then recovery. These stages replace the majority influenced, co-dependency model of treatment. Inclan warns that the concept of co-dependence in work with Hispanic/Latino families can lead to defining their cultural values as pathological, and therefore has no place in the treatment process. These cultural values include a strong sense of family, which dictates loyalty and interdependence among family members, and which urges women in particular to make sacrifices for the sake of their husbands and families. This is in direct conflict with the co-

dependency model's recommendation that family members reject the substance abuser until he/she seeks treatment. Also, traditional support groups directed toward family members clash with the Latino's concept of *verguenza,* or shame (Inclan & Hernandez, 1992). Many Latinos believe that it is inappropriate to bring shame to the family name, so support groups in which members discuss their personal experiences with a given problem are generally not helpful.

Language continues to be a barrier for effective treatment for many Latinos. There is evidence that providing Spanish speakers and Spanish language materials in programs increases utilization rates of Latinos (Tharp, 1991). More importantly, it reduces the risk of misdiagnosing language delays, as evidenced by the following case study:

> Juanita, a four-year old Latino girl, was brought to a clinic by her foster parents for an initial medical appointment. Juanita had been removed from the care of her biological mother due to her mother's uncontrollable drug use, and had been placed in an Italian-American foster home several days prior to her clinic visit. The foster parents expressed concern that Juanita had a language delay because she only spoke a few words and used gesturing as her primary method of communication. It was suspected that her natural mother's drug use had prevented her from teaching the child to talk and from seeking therapy for Juanita's language delay.
>
> After a physical was completed by a member of the medical staff, it was determined that the child did have a severe language delay. Consequently, the child was going to be referred for further evaluation so that she could be placed in an early intervention program to address her delays. However, before the referral was made, a Spanish-speaking nurse practitioner began to talk to Juanita in Spanish. It was discovered that Juanita spoke fluent Spanish in relation to her age. This revelation changed the focus of treatment from a language delay to the problem of having non-Spanish- speaking foster parents.

As a program, we learned not to jump to the conclusion that a child has a language delay when an assessment is conducted only in the English language. In general, English-speaking professionals, should not assume that children who do not speak English have language delays.

Along with the concept of language, time, religion, help-seeking patterns and gender orientation are also important variables in the treatment process (Inclan & Hernandez, 1992). The P.A.C.T. program has witnessed the unique help-seeking pattern of many Latina mothers, who concentrate on getting medical assistance for their partners and children and put aside their own severe medical needs. Many Latino families treat the P.A.C.T. staff members as family members, giving them gifts and inviting them to family functions and staff have learned that it is disrespectful to turn down their offerings. This conflicts with the unwritten rule that professionals are not supposed to develop personal relationships with their clients. The P.A.C.T. program continues to employ Latinos and participate in client family gatherings in order to increase its understanding of Latino culture.

The Struggles Women Confront

Mothers with drug addiction problems face obstacles in accessing services, in overcoming their drug addiction, and in caring for their children. In addition to substance abuse, these women's lives are complicated by poverty, violence, health problems, histories of child abuse and neglect, and decaying neighborhoods. It is important to assess all of these issues when attempting to provide services to this complex population.

Counterproductive Institutional Responses

One system obstacle that contributes to drug-addicted women's poor utilization of services is the blaming attitude that many health care and human service providers take when working with this population. Women are seen as being to blame for their addiction and are more often viewed with contempt then are male substance abusers (Gustavsson, 1991). This attitude seems even more widely held towards pregnant substance abusers. Society in general, as well as many health and human service providers, seem to believe that pregnancy should somehow be a cure for drug addiction. This belief contributes to the judgmental attitudes that pregnant drug-addicted women often face, which increase their feeling of guilt and further depress their self-esteem (Finkelstein, Brown & Qamar, 1981). It is imperative for agencies to provide education on the disease model of addiction so that service providers can gain an appreciation of the difficulty of stopping all drug use and to hopefully sensitize their practice with pregnant drug-addicted women.

A related system obstacle is the very public debate of whether to provide treatment to pregnant substance abusing women or to prosecute them criminally. Pregnant women appear to have an increased chance of being incarcerated for a drug-related offense because some judges feel that by doing this, they are protecting the unborn child (Gustavsson, 1991). Even though there are few states that take the prosecution route, women have reported that they did not seek prenatal care because they thought child protection authorities would be called, and they feared that they would lose custody of their other children.

A third system obstacle is service providers' failure to recognize and address the immediate needs of women and their families. For example, many women who seek treatment are homeless or living in substandard housing or drug-infested neighborhoods. It is difficult for them to focus on parenting and recovery if basic needs are not met. Even though the drug use may be the reason for the substandard living situation, it is important to first help families meet their basic needs before expecting them to meet drug treatment requirements.

The above system obstacles mainly stem from service providers' and society's lack of understanding of the special needs of women in general, and more specifically, of drug-addicted mothers. However, many barriers are related to a lack of available services. There is, for example, a lack of drug treatment services specializing in the treatment of women. The traditional male-oriented treatment models have been found to be ineffective when working with

women (Kaplan-Sanoff & Fitzgerald, 1992). Women often find the confrontational approach traditionally taken by substance abuse counselors to be very threatening, and as many drug-addicted women have histories of being abused, it is not difficult to understand why this approach is unsuccessful .

Luckily, the Buffalo area has enjoyed an outpatient service that was specifically designed to treat this population. In addition, an ongoing commitment from the local office of Alcohol and Substance Abuse Services is responsible for the training of other treatment programs on effectively engaging and treating drug-addicted women.

Even though Buffalo area treatment services are increasingly more sensitive to the needs of pregnant women, they often do not have the ability to provide for needs such as day care and transportation. Lack of day care is the most commonly cited problem by P.A.C.T. program clients. It is extremely important to help mothers both find appropriate day care and advocate for social services to approve payment for it. Too often, child protection or children's services will tell a mother to find a friend or family member to watch their child when this is not an option for many women.

There is also a tremendous lack of inpatient services in general, and very few residential treatment programs for women and children. Furthermore, many wonen have no option but to place their children in foster care if they need inpatient treatment. This is a painful decision and one that many women can't make as they fear that they will never get their children back. Even when women are able to make arrangements for the care of their children, it is increasingly hard to get an inpatient stay approved by either private or public health insurance companies. The following case study will highlight the difficulties one mother faced in entering an inpatient rehabilitation program.

Mary is a 26-year-old African-American mother of a ten month-old son and five-year-old daughter. Mary began using alcohol and marijuana at the age of fifteen. She began using crack cocaine three years ago when she began dating a drug dealer. Mary's ten-month-old son was born with a positive drug test for cocaine. Child Protection allowed Mary to take her son home from the hospital as she agreed to seek drug treatment for herself and medical care for her child. Mary rarely followed through with her outpatient drug treatment program, but was very conscientious in keeping all of her baby's health care appointments and appeared to be meeting both of her children's basic needs. After 60 days, Child Protection closed her case and Mary stopped going to drug treatment and was terminated from the agency. Mary cited inadequate day care as the reason why she had not followed through with drug treatment, as well as her belief that she didn't have a serious drug problem.

Mary increasingly began to ask for assistance with food, diapers, and formula, and was no longer keeping her baby's doctor appointments. In addition, her mother had confided in an outreach worker that Mary had begun leaving her children with her for days at a time. Both the social worker and the outreach worker discussed with Mary the changes that they had seen in her. At first, Mary denied that she was using any drugs, but a week later called the social worker requesting assistance in entering detox and then a 28-day rehabilitation program. Mary confessed to using crack and alcohol daily and said she no longer wanted to live that way as she had begun using her body to get drugs and her mother was threatening to call Child Protection.

The first step in getting Mary into a 33-day inpatient program was finding someone to care for her two children. Even though Mary's mother had been primarily caring for her children, she was unable to do so on an extended basis as she was in poor health. Mary has 8 siblings, but none would agree to care for her children for that length of time. Mary agreed to place her children in respite foster care, which required a referral to Children's Services. The Children's Services worker first tried to talk Mary into entering an outpatient program and when Mary stressed to her that she had had a string of unsuccessful outpatient treatments, the worker then requested that she talk to her family again about caring for her children. Mary told the worker that she had already done this and no one in her family was able to help her. The worker finally agreed to make the referral for respite foster care, but stressed this could not exceed 30 days and that if it did, then Mary would face problems in getting her children back. Mary's mother agreed to keep the children for the last three days of Mary's 33-day inpatient program (7-day detox and 28-day rehabilitation). The children were placed in a non-relative foster home three weeks later when Mary was able to get a bed at a local detox.

Upon admission to the hospital, Mary was told that her insurance would not pay for an inpatient program without pre-approval. Even though Mary had Medicaid, it was being managed by a Health Maintenance Organization. If she wanted to cancel her HMO and get back into the Medicaid system, then she would need to wait 30 days. Mary became increasingly upset as her HMO denied her inpatient stay. She was told she needed to first prove herself in an outpatient program by being compliant. Mary feared that she would be unable to do this as she was using two to three hundred dollars of crack each day. In addition, her children were already in the foster home and their stay there could not exceed 30 days.

Mary was referred to an intensive daily outpatient program and attended NA meeting at night. After two weeks, her counselor was able to get the HMO to approve an inpatient program. Mary's mother agreed to keep the children for a longer period of time as Children's Services offered to provide her with respite day care.

Luckily, Mary was able to hang in there and follow through with her outpatient program as she was truly committed to overcoming her drug addiction. However, the P.A.C.T. program has worked with many women and the majority would not have been able to overcome all of these barriers and trust the system enough to place their children in foster care. It is a great testament to this client's perseverance that she was able to do so.

The social worker and the outreach worker provided daily support to Mary through phone contact as well as home visits. The program had funding to pay for a bus pass for Mary so that she would have transportation to her drug treatment program as well as to her NA meetings. Both workers acted as advocates for Mary throughout the process of enrolling in an inpatient program.

Dysfunctional Families and Communities

Women with drug addiction problems are often estranged from their family of origin, their extended family, and their community. Because of past drug seeking behaviors that resulted in lying to and stealing from their families, drug-addicted women have many times "burned their bridges" by the time they present for services. In the case of Mary, the reason why many of her siblings were unwilling to help her was because they did not believe that Mary was sincere about stopping her drug use. One brother said that Mary had lied to him so many times before that he was unwilling to take on the added responsibility of her children as he believed as soon as Mary completed her inpatient program, she would return to the same lifestyle.

In many of the women's cases, alienation from family is not the only problem. Many report growing up in homes marked by substance abuse, neglect, sexual abuse, and abandonment. Research has shown that 75 to 90 percent of women utilizing inpatient treatment services have reported childhood sexual abuse (Roshenow, Corbet, & Devine, 1988). A history of family dysfunction may complicate the woman's recovery as many women use drugs to numb emotional pain, making abstinence a difficult challenge as illustrated in the following case study.

Margarita is a 23-year-old Hispanic mother of four children. She was born in Puerto Rico and moved to New York City with an older sister when she was 15. Margarita moved to New York because she was pregnant with her father's child. He had been sexually abusing her since the age of 11. Her mother, who remained in Puerto Rico, agreed to raise the child. Her mother had said that she had been unaware of Margarita's father's sexual abuse of her and left him shortly thereafter.

Margarita reported that she had been using marijuana and alcohol since the age of 13 and began using crack cocaine at the age of 16 when she became involved with a cocaine user who was also selling drugs to support his habit. Margarita subsequently had two children by this man, but left him as he was becoming increasingly violent towards her and the children. Eventually, she had to leave New York City as this man would not stop harassing her.

Margarita reported that after this episode, she was able to stay clean for a few months, until she became involved with yet another drug user. Again, she became pregnant, but stated that she did not want to have another cocaine-exposed child so she sought treatment and prenatal care early in the pregnancy. Through her prenatal care, she was diagnosed as HIV positive, as was her partner. He blamed her for infecting him, even though he had a history of homosexual relationships and was more likely to have been infected this way. Margarita had no family supports in Buffalo, her partner blamed her for infecting him with HIV, she was 3 months pregnant, HIV positive, and suffered from anxiety attacks related to her childhood sexual abuse. Her drug use was the only way she believed she had of coping with these monumental problems. Margarita stated that she did not feel that therapy would help her as it hadn't in the past, and now that she feared dying of AIDS, she felt there was little a therapist could do to help her. She did not respond to the outreach efforts of a local outpatient drug treatment program, but did follow through with her prenatal care and her HIV care. Since her child's birth, she has worked closely with a peer worker who is also HIV positive. She continues to struggle with her drug use and all efforts to date to refer her for both drug treatment and psychotherapy to address sexual abuse have been unsuccessful.

The social worker continues to work with this mother on parenting issues and making plans for her children's care should she become too ill to care for them. Margarita's drug use has not impaired her ability to provide a minimal degree of care for her children, but does interfere with her own health and threatens to become more of a problem if her use continues to escalate. The social worker, as well as the outreach worker, have told Margarita that if her drug use interferes with her ability to parent, then Child Protection will be called.

In addition to the traumatic family histories these women are struggling with, they are also faced with a high incidence of crime and violence in the communities in which they live. The problem of crack and violence in the inner cities has reached epidemic proportions, making recovery in this context difficult as the availability of the drug is very high, and is an integral part of a drug-addicted woman's social life. Walker and Small (1991) contend that "crack fits the psychological and economic needs of a rapidly disorganizing system." Community deterioration is also related to the migration of middle-class African-Americans and Hispanic/Latinos out of the inner city so that there is a gap in inner city leadership and a minimum of healthy minority role models.

Drug-addicted women see few options for themselves and often need encouragement to identify long-term goals. Because the communities in which many of these women live are so impoverished, there are few positive examples of what can be gained by staying clean and eventually pursuing career and educational opportunities. Crack helps boost self-esteem and makes living in this environment bearable. Therefore, if programs that serve this population are to be successful, they need to take these factors into account and hopefully make vocational guidance and training part of their programs. In a larger context, society in general needs to address the problems of crime, joblessness, poor housing, and the problems in our educational system in order to reduce the increasing number of drug-addicted children and adults.

Personal Obstacles

Even when programs are sensitive to the needs of drug-addicted women and have taken steps to address as many of the aforementioned obstacles as possible, the women have their own barriers to overcome.

Perhaps women's primary obstacle to accessing services is continued substance abuse. If a woman's priority is getting high, then seeking medical and social services for her child is secondary. As is true for all addicts, the first step of treatment is acknowledging the addiction. If a woman is denying or minimizing her drug use, then efforts to get her into treatment are usually futile. Even when women are able to stop their crack use, they often continue to abuse alcohol because they fail to address the underlying cause of their addiction, or else view crack as their only addiction.

Cocaine and/or crack-addicted women often find themselves spending all of their energy on either using drugs or getting the money to purchase more drugs to use. Trading or bartering sex-for-drugs is commonly reported among female crack users, as is stealing. Because of the time and energy it takes to maintain a crack habit, there is often little time left to utilize health and human services. Crack creates a vicious circle of physical and psychological highs and lows that requires increasing amounts of the drug to maintain the good feeling. Therefore, even when women are sincere about following through with services, they are often not able to bear the "crash" that follows the high long enough to utilize those services.

Women who have partners with substance abuse problems also have obstacles to utilizing services. Many women stay in a relationship where their partner's continued drug use sabotages their own attempts at recovery. Even women who appear genuinely committed to their recovery are often unable to break out of relationships in which their partner continues to use. Emotional and physical abuse often contribute to their inability to leave these relationships. In addition, many times these men are the fathers of their children and the women want to maintain the parental relationship. As is widely known, it is very difficult to maintain abstinence if one is intimately involved with another addict. Also, many times the men feel threatened by their partner's recovery and try to actively entice them into using drugs again.

The physical health of these women may also present a barrier to recovery and caring for their children. Long-term substance abuse, poor nutrition, and poor medical care often complicate the treatment picture. In addition, because of the practice of trading sex-for-drugs and using IV drugs, there are increasing numbers of women in this population infected with HIV. As was illustrated in the previous case study, the diagnosis of HIV can hinder treatment as the initial reaction is often one of hopelessness and can lead to a "why bother" attitude. However, in some cases, it can strengthen a woman's resolve to achieve sobriety or help maintain it as shown in the following case study:

Sonya is a 45-year-old African-American mother of a newborn son and a 16-year-old daughter. Sonya was diagnosed with HIV in her third month of pregnancy and after being drug-free for five years. She had a good job and was recently married to a man who had no substance abuse history. Sonya had agreed to the HIV testing as her doctor had told her it would be a good idea because of her IV drug use history. Sonya had no symptoms and suspected that the test would be negative.

When Sonya was told she was HIV positive, her initial reaction was one of disbelief. She stopped going to the doctor for a few months and later reported she was very much in denial, as was her husband. Sonya developed a yeast infection in her fifth month of pregnancy which prompted her to return to her doctor for care. She began seeing a social worker at AIDS Community Services at this point as she wanted to find out as much as possible about the disease, and also felt she needed someone to talk to because her husband, who tested negative, was still refusing to discuss the subject.

Sonya later reported that during this time she began attending NA and AA meetings daily as her urge to use drugs to cope with the news of her diagnosis was ever present. In addition to her concerns about her own health, she was constantly worrying that her baby would also test positive. She and her husband had been so excited about her pregnancy and she had been feeling confident about herself and her sobriety. It seemed to Sonya that God was "punishing" her for her past behavior just when she was truly content.

Sonya remained drug-free throughout her pregnancy and remains drug-free today. She utilizes her support network very effectively and states that "I'm going to live whatever life I have left drug-free." Even though Sonya has experienced much rejection from some of her friends and family, she has been able to overcome this and reports that her diagnosis has strengthened both her sobriety and her relationships with her "true friends" who have not rejected her, but embraced her.

It is very important for health and human service providers to realize how devastating a diagnosis of HIV is to both the infected person and to his/her significant others. It is extremely

important to be knowledgeable about HIV so correct information can be relayed to the client. Practitioners can provide support, understanding, and advocacy for their clients and minimize as many barriers as possible. The likelihood of relapse is very high when a client is first diagnosed with HIV, therefore intensive supportive efforts need to made during this time. This may include frequent face-to-face contact, accompanying clients to first medical appointments, and if the client requests, meeting with family members to both educate and support them. Finally, linking HIV-positive people together through support groups is perhaps the most effective intervention as newly diagnosed people know they are not alone and that there is a life after an HIV diagnosis.

The final obstacle in this category is created by the criminal activity drug-addicted women often engage in to finance their habits. Obviously, if a woman is incarcerated, then services are rarely provided. Incarceration does not necessarily lead to being drug-free as drugs may be readily available in some prisons.

Not only do the women not receive treatment for their drug addiction, but their children often end up in foster care. Visitation between the mother and the child is strictly limited. Needless to say, this seriously retards bonding and attachment between mother and child, which may cause problems upon reunification because the child may grow too attached to a different caretaker, causing the mother to feel rejected.

As society increasingly looks towards incarceration to solve drug problems, as opposed to treatment, this obstacle has little hope of being removed. As stated previously, some judges treat pregnant drug-addicted women more harshly than other first-time drug offenders as they believe they are protecting an unborn child. Gustavsson (1991) decries this practice by stating, "that jails are safe environments for pregnant women is at best a questionable assumption."

Conclusion

The P.A.C.T. program has been in existence for almost seven years now and has learned some very valuable lessons that can be shared with other practitioners. As mentioned previously, it is very important for practitioners to have an understanding of the disease model of addictions. Over the years, we have worked with many women in various stages of recovery, and unless one understands addiction as a chronic relapsing disease, it is almost impossible to work effectively with this population. It is important for our clients to know that if they do relapse, they can come to us for help and not fear rejection, recrimination, and compounded disappointment. We have also come to realize that detoxification and rehabilitation programs are only small, but important, steps in the recovery process. We have seen countless numbers of women refuse follow-up outpatient programs because they have successfully completed an inpatient program, then relapse shortly thereafter. Because crack cocaine is such a powerful drug and so readily available, a great deal of peer and professional support is necessary for women in recovery to maintain abstinence.

Another lesson that we have learned is the importance of being non-judgmental and honest with our clients. Unless families feel that they can trust us, they will not seek help from us. If families perceive us as trying to take their children away from them rather than wanting to provide services to prevent this from happening, then they will most likely deny their substance abuse until it does indeed cost them their children. In this regard, it is important to be honest with families
when making child protection reports. In general, if professionals fail to tell families that they are planning to report them to Child Protection, then any trust that has been built is immediately destroyed. We have found that we can keep a family's trust by explaining why it is necessary to make a report, while at the same time assuring them of our advocacy for family maintenance whenever possible.

One of the hardest lessons that we have learned is that in order to protect children, it is at times necessary to remove them from their birth families. We have seen women jeopardize their children's lives in order to get high. When getting high is more important than meeting a child's basic survival needs, we as service providers need to confront the family and advocate for the child. There is practice evidence that the threat of loss of children is the intervention that has caused women to stop denying that they have a problem (Chasnoff, 1990, 1989; Feig, 1990). It becomes the intervention that causes them to seek the services they need to address their drug addiction. We have learned, however, that even losing one's children is sometimes not a powerful enough incentive to stop some women from abusing drugs.

Perhaps the most important lesson we have learned involves the necessity to acknowledge our own needs and limitations as helpers. Working with this population of women and children can be very stressful unless we recognize that although we may provide the most comprehensive services possible, it is still up to the women we work with to want to stop using drugs. It is important to have staff support groups, peer supervision, and clinical supervision so that we can meet our own needs for nurturance and support.

References

Bennett, M. (1986). A developmental approach to training for intercultural sensitivity, International Journal of Intercultural Relations, 1, 179-196.

Black, R., & Mayer, J. (1980). Parents with special problems: Alcoholism and opiate addiction. In H. Kempe & R. Helfer (Eds.), The Battered Child, (3rd. Ed.), (pp. 104-113). Chicago: University of Chicago Press.

Brill, N. (1985). Working with people: The helping process. NewYork: Longman, Inc.

Chasnoff, I.J. (1991). Underdetection of substance abuse. New England Journal of Medicine, 325(14), 1045-1046.

Chasnoff, I.J. (1990). Cocaine babies, Healthcare Executive Currents, 34(1), 1-2.

Chasnoff, I.J. (1989). Drug use and women: Establishing a standard of care, Annals of the New York Academy of Science, 562, 208-210.

Devore, W., & Schlesinger, E. (1986). Ethnic-sensitive social work practice. Columbus: Charles E. Merrill Publishing.

Feig, L. (1990). Drug exposed infants and children: Service needs and policy questions. Washington, DC: U.S. Department of Health and Human Services.

Finkelstein, N., Brown, K., & Qamar. C. (1981). Alcoholic mothers and guilt: Issues for caregivers. Alcohol Health and Research World, Fall, 45-49.

Gustavsson, N.S. (1991). Pregnant chemically dependent women: The new criminals, Women and Social Work, 6(2), 61-73.

Inclan, J., & Hernandez, M. (1992). Cross-cultural perspectives and codependence: The case of poor Hispanics. American Journal of Orthopsychiatry, 62(2), 245-255.

Kaplan-Sanoff, M., & Fitzgerald, K. (1992). Working with addicted women in recovery and their children: Lessons learned in Boston's City's women and infants clinic. Zero to Three, 13(1), 17-22.

Kavanagh, K.H., & Kennedy, P.H. (1992). Promoting cultural diversity: Strategies for health care professionals. Newbury Park: Sage Publications, Inc.

Midgley, J. (1991). Social development and multicultural social work, Journal of Multicultural Social Work, 1(1), 85-100.

Mio, J. (1989). Experiential involvement as adjunct to teaching cultural sensitivity, Journal of Multicultural Counseling and Development, 1(7), 38-46.

National Institute on Drug Abuse (1989). National household survey on drug abuse: Population estimates 1988 (DHHS Pub. No. (ADM) 891636). Washington, DC: Government printing office.

Orlandi, M.A. (1992). The challenge of evaluating community-based prevention programs: A cross-cultural prospective. In M.A. Orlandi (Ed.), USDHHS (publication #(ADM)921884). Washington, DC: Alcohol, Drug Abuse, and Mental Health Administration, Office for Substance Abuse Prevention (OSAP).

PolitiZiter, M. (1987). Culturally sensitive treatment of Black alcoholic families, Social Work, 32(2), 130-135.

Robinson, J. (1989). Clinical treatment of Black families: Issues and strategies, Social Work, 34(4), 323-329.

Roshenow, D., Corbett, R., & Devine, D. (1988). Molested as children: A hidden contribution to substance abuse? Journal of Substance Abuse Treatment, 5, 13-18.

Stevenson, K., Cheung, K., & Leung, P. (1992). A new approach to training child protective service workers for ethnically sensitive practice, Child Welfare League of America, 71(4), 291-305.

Tharp, R. (1991). Cultural diversity and treatment of children, Journal of Consulting and Clinical Psychology, 59(6), 799-812.

Walker, G., & Small, S. (1991). AIDS, crack, poverty, and race in the African-American community: The need for an ecosystemic approach, Family Systems Application to Social Work, 5, 3-4, 69-91.

Chapter 4

ASSISTING AFRICAN-AMERICAN WOMEN IN ACCESSING SUBSTANCE ABUSE TREATMENT SERVICES

Laura W. MacDonald, MA
Operation PAR
Pinellas County, Florida

Shirley M. Davis, MS
Davis Associates
Pinellas County, Florida

Introduction

> *When we want help, white America is nowhere to be found. When, however, you decide that we need help, you are there in a flash, solution in hand. You then seek to impose that solution on us, without seeking our views, hearing our experiences, or taking account of our needs and desires. We tell you that we fear genocide and you quarrel with our use of the term. Then you try to turn our concerns back on us. 'Don't you know,' you ask us in an arch tone of voice, 'that while you are standing on ceremony, thousands of the very people you say you care about are dying of AIDS?' Struggling to ignore the insulting implication that we are profoundly retarded or monumentally callous we respond, 'Don't you know that they are already dying from drug overdoses, Uzis and AK-47s, joblessness, despair and societal indifference?' And, white America, you sigh and say, 'What's one thing got to do with the other?' Then we sigh and wonder if you truly do not understand" (Dalton,1989).*

Traditionally, drug treatment programs have focused on white male addicts and the resources needed to help them in their recovery (Vannicelli, 1984). Early efforts to identify the treatment needs of women concentrated on studying white heroin addicted women (National Institute on Drug Abuse, 1979). It has only been in recent years that increasing attention has been given to the treatment of women of childbearing age and the resources they need to recover from addiction. Unfortunately, scant attention has been given to examining differences between African-American and white women in their willingness to enter treatment and the barriers they face when trying to do so.

It is now generally accepted that there are differences between men and women in the sociocultural factors which contribute to their substance use (Lex, 1991). Men and women are socialized differently. As a result, women generally have fewer assertiveness skills and will need more supportive networks in order to remain drug and/or alcohol free (Marsh and Miller, 1985). In our society, women's social status generally derives from men and the drugs they use are often

obtained from men. Very often women addicts have been sexually abused (Wildwind and Samson, 1981). Family substance abuse, sexual abuse, age of first depressive symptoms, and age of first illicit drug use have been found to be significantly correlated for both white and African-American women (Boyd, 1993).

Cultural Baggage

> *In one second I realized that I had done just what they feared of me. That I had overstepped the unwritten rules which I knew I should have respected. Instead, I had brazenly and boldly come to their table and spoken out on, of all things, loneliness (Angelou, 1993).*

In order to be successful in attempting to draw women into treatment, one must remain cognizant of gender differences within our society. Similarly, when interested in serving a specific subculture of women within our society such as African-American women, one needs to be aware of social nuances within the subculture which may deter, restrict, or inhibit their entry into treatment and may influence treatment outcome. For any person, regardless of sex, race, or ethnic background, substance abuse treatment must be culturally relevant. That is, it must take into account the social milieu of the potential program participant. One must examine cultural factors which may prove to be areas of resistance to treatment and the recovery process.

Values, attitudes, and communication patterns are unique aspects of a culture (Thompson, et al., 1990). The concept of time, attitudes toward health providers and persons in authority, sex roles, socialization, spiritual practices, personal space, use of leisure time, and the value of the family are culture specific. For African-American individuals, four systems have been identified as the means by which social development, cultural focus, and cultural patterning are achieved: church; community; neighborhood; and social organizations (Butler, 1992). For many African-Americans in recovery, the church is an important part of their sobriety (Bell, 1993). Often a lack of knowledge and awareness with regard to the lifestyle patterns and needs of minorities have resulted in inadequate service delivery, lack of compliance, and inconsistent or poor responses to service providers and treatment services (Butler, 1992).

In addition to culture, there are historical, social, political, and economic factors which significantly impact the lives of individuals (Grace, 1992). African-Americans in this country face racism, segregation, poverty, and discrimination which often results in feelings of powerlessness and alienation (Kleber, 1993). Chestang's categorization of the elements of racism are worthwhile to consider in assessing the impact of racism on personality. "These elements are social injustice...the denial of legal rights; social inconsistence...the institutionalized disparity between word and deed; and impotence...the feeling of powerlessness to influence the environment" (Chestang, 1972). Common social problems which have resulted include poor educational and employment opportunities, crime, homelessness, high mortality and morbidity rates, and widespread substance abuse. Alcohol and other drugs often serve to provide an escape from reality and are used to combat feelings of depression and frustration.

Problems that are specific to many African-American substance abusers include low self-esteem; late entry into recovery, which is often prompted by the criminal justice system; a focus on short-term abstinence rather than long-term recovery within the African-American community; speech patterns and dialect which are different from those of the dominant culture; a unique, often dysfunctional family structure; institutionalized racism; and internalized racism (Smith, et al., 1993). Culturally appropriate and culturally responsive interventions and recovery activities need to be utilized to facilitate the substance abuser's entry into treatment and to sustain participation in the treatment.

Barriers to Access

A recent study of pregnant and postpartum women in substance abuse treatment facilities in the southeastern United States identified the major barriers faced by women enrolling in treatment. These barriers proved to be self-perceived rather than logistical or systemic in nature. Major barriers included issues such as fear of losing their children, shame, depression, and denial (Gehshan, 1993). Women may also fear that their partners will abuse them or leave them if they seek treatment services (Center for Substance Abuse Prevention, 1993). In addition to these self-imposed obstacles, other identified barriers include a lack of money, wait lists for treatment slots, limited service availability for pregnant women, lack of child care, unsafe housing, and poor transportation (Gehshan, 1993).

Women seek treatment for a variety of reasons, including pressure from their families, concern for their children, or pressure from the legal system (Gehshan, 1993). Women have a host of problems that are different from the problems men face when attempting to enter treatment. Therefore, in order to be effective, treatment services for substance abusing women need to be different from treatment for men. One of the most difficult aspects of treatment is identifying these women who need treatment and drawing them into care (Hailer, 1991). So that women may benefit from active recruitment and outreach efforts designed to help them overcome self-imposed barriers, substance abuse treatment for women needs to be designed to meet the needs of women.

In the State of Florida, as in many other states, it is illegal (Florida Statute 397) to use drugs while pregnant. Should an infant have a positive urine toxicology the substance abusing mother faces the possibility of having her newborn taken away from her at birth. As a result, pregnant substance abusers are often suspicious of the "system." Many women access prenatal care late in their pregnancies or present at the time of delivery having received no prenatal care because of that suspicion.

It is known that this is just one of the many reasons why high-risk parents often fear social service agencies, protective service action, strangers, talking about personal issues and labeling (Kumpher, 1991). Nontraditional outreach methods using ex-addicts, aggressive outreach techniques, and immediate response may be effective in reducing preadmission hurdles (Richmond, 1991). Moreover, substance abusing women frequently do not know about available treatment services and the means by which to access those services. This naivete, coupled with

their fear of the "system," means that often the principle barrier is just getting them through the door of a treatment center. Other common barriers include a lack of resources such as child care, transportation, and safe housing, as well as a lack of self-esteem (Chasnoff, 1993).

For African-American women, these problems are often compounded if issues of culture are not addressed. African-American women may be more suspicious of the *"system"* than white women, particularly if they perceive that they are being manipulated by the dominant culture. Their fears may be well founded. In a drug prevalence study conducted in Pinellas County, Florida, among pregnant women, substance use rates were similar for African-American (14.1%) and white women (15.4%). However, African-American women were ten times more likely to be reported to authorities at the time of delivery than were white women (Chasnoff, 1990).

Additionally, self-perceived barriers may be greater for African-American women than for white women. Self-esteem, for example, may be lower among African-American substance abusers than among white substance abusers. Higher rates of single parenthood and diminished social support, due in part to the process of addiction and its correlates (e.g., increased criminal involvement, violence), may have a negative impact on African-American women's ability to enter treatment (Freier, et al., 1991). Drug-addicted women in general, and drug-addicted African-American women in particular, face problems other than their addiction. They frequently have numerous financial, legal, health, social, and psychological problems. These problems often include poor housing, inadequate income, a lack of education, and emotional difficulties. Physical and/or sexual abuse during childhood is common among these women (Boyd, 1993), and many have histories which include abusive or violent relationships with men (Gehshan, 1993).

Research has found that substance abusing women with lower levels of self-esteem and higher levels of emotional distress have more difficulty participating in drug treatment and are pessimistic about the prospect of making positive changes in their lives (Reed and Moise, 1987). African-Americans may also be less comfortable with self-disclosure in therapy or more skeptical of the idea that personal problems are best handled with the help of professionals (Longshore, et al., 1993). Intervention workers and substance abuse treatment providers need to be aware that different cultures have different cultural boundaries. A cultural boundary is defined as "an invisible line around us that defines what's okay for other people to do and say to us and what's not okay" (Bell, 1993). However, one cannot assume that African-Americans are reluctant to seek treatment solely because of their own issues. The nature of available services can also be a problem. For example, 12-step recovery groups are often viewed by African-Americans as exclusively white and middle class, and interpret the 12-step idea of *powerlessness* with negative aspects of religiosity (Smith, et al., 1993).

What May Work and Why

Substance abusing women often view treatment as a way to ward off negative consequences of their drug use, such as loss of child custody or incarceration. Generally, they are only ready to enter treatment when they are at a crisis point in their lives and need stabilization. It is only after

critical factors such as housing, child care, transportation, medical assistance, and the like are met that the female addict can begin to focus on her addiction (Hailer, 1991). Assisting a woman in accessing these other services may help to establish trust between her and her counselor or case manager. Since the initial commitment to treatment may be more tenuous among African-American substance abusers, special emphasis should be placed to engage African-Americans at each step of the treatment entry process: outreach, referral, and intake (Longshore, et al., 1993).

Providing women with up-front intervention services that reduce real and self-perceived barriers to treatment and increase their ability to adjust to a program may help them to follow through with treatment recommendations. Furnishing early intervention services to women who may be placed on a wait list for treatment may make them more willing to enroll in treatment services (Ravndal and Vaglum, 1992). It is unfortunate that there is a lack of literature about the influence of different intake procedures on the initiation of treatment. There have been a few studies using wait list controls (Eriksen, 1986; Grenier, 1985), but the effects of different selection procedures are unknown (Ravndal and Vaglum, 1992). This is especially true in the treatment of African-American women. Providing up-front case management services designed to help stabilize the woman and make the transition to treatment easier may increase retention rates (Hailer, 1991). To help potential clients overcome their fears, the professional helper needs to develop a relationship of mutual trust and respect which often requires a great deal of time and effort. For example, if a woman is afraid that State intervention may lead to the loss of her child(ren), the professional helper can allay her fear by clarifying the law and program regulations which may affect her situation. Explaining the confidentiality regulations of the agency and reporting requirements for child abuse and neglect in a way which demonstrates that the clinician has the woman's welfare in mind may assist in establishing trust (Kumpher, 1991).

It is known that children are an important force in the lives of addicted parents, either as a motivation to halt drug use or as an additional strain at a time when parents, particularly mothers, need to focus on their own needs for treatment. Providing comprehensive services prior to and during the enrollment period for substance abuse treatment services has proven successful in alleviating personal problems of substance abusing mothers. This outreach approach can also influence the treatment success of program participants, particularly mothers of small children (Eldred, et al., 1974).

Moreover, it is known that a substance abuse counselor's or case manager's therapeutic style may affect treatment outcome. Clients of those counselors who possess "accurate empathy" generally have better treatment outcomes, and therapist empathy has also been identified as a key element in successful brief interventions (Miller, 1992). The degree of empathy experienced by the client is considered one of the most salient elements in the treatment relationship, and its absence frequently has led to the client's premature withdrawal from treatment (Katz, 1963). By choosing not to acknowledge or elicit a program participant's perspective regarding race, counselors may fail to form an alliance which the client experiences as empathetic (Robinson, 1989). It is vital that program staff are trained to be "ethnically competent," which is defined as able to conduct one's professional work in a manner that is comparable with the behavior and expectations that members of a culture recognize as appropriate among themselves (Green, 1982). Characteristics

of ethnic competence have been delineated as: being aware of one's own cultural limitations; being open to cultural differences; utilizing cultural resources; acknowledging cultural integrity; and possessing a client-oriented, systematic, learning style (Green, 1982).

Operation PAR, Inc. (Parental Awareness and Responsibility)

Operation PAR, Inc. (Parental Awareness and Responsibility) is involved in research and training in the area of maternal substance abuse and offers a continuum of services to this population. The program includes early intervention services, case management services, outpatient treatment, day treatment, short and long term residential treatment, detoxification services and methadone maintenance. Operation PAR also provides early intervention developmental day care services to children under five years of age whose mothers are PAR clients. The assumption underlying the development of this program was that female substance abusers providing up-front crisis intervention services designed to facilitate entry into treatment would increase the likelihood that they would enroll in treatment services.

The Maternal Substance Abuse Intervention Team

With these issues in mind, Operation PAR, Inc. developed the Maternal Substance Abuse Intervention Team, also known as the I-Team. The program was specifically designed to assist pregnant and postpartum women in accessing treatment services. Funding was provided through the National Center for Substance Abuse Prevention (formerly the Office for Substance Abuse Prevention) under the Pregnant and Postpartum Women and Infants Demonstrations Division for a four-year period from February 1990 through January 1994. Referrals to the program were received from April 1990 through September 1993.

It was expected that approximately 75% of the clients referred to the I-Team would be African-American women, and the staffing composition for the program was composed to reflect similar percentages of African-Americans. Other infrastructural components have been identified as crucial in the provision of culturally relevant services (Perez-Arce, et al., 1993) and were established at the onset of the program in order to provide culturally relevant services. These components included locating the main program office and satellite offices in areas which were in the community of the target population or accessible to the target population through public transportation, staff training in cultural sensitivity, and the selection of staff members who were both African-American and in recovery to serve as role models for potential clients. The I-Team was a multidisciplinary team composed of a Program Coordinator, two Substance Abuse Specialists, a Community Health Nurse, and a Clinical Social Worker. They provided the case management and intervention services necessary to get female substance abusers into treatment. Auxiliary services were provided through referral to appropriate community agencies.

The team developed and maintained linkages with social service agencies that provide services to the target population, such as AFDC, WIC, Medicaid, and referrals to employment, medical, and housing services. Since potential clients present a variety of challenges to successful

treatment, the program employed an interdisciplinary frontline clinical staff. This approach has been widely advocated to enhance effectiveness (Craig, 1987), and reflects the diverse needs of participants and of the problems to be addressed.

The clinical staff provided services which included identification, assessment, intervention, referral, and tracking of maternal substance abusers. Data was gathered pertaining to any obstacles program participants and clinicians encountered when attempting to coordinate treatment services. An in-depth biopsychosocial assessment was conducted in the woman's home or at the worker's office depending on the wishes of the potential client. A thorough biopsychosocial assessment, which examines both strengths and weaknesses of the client, and covers behavioral, medical, psychological, and social dimensions, is thought to be useful in matching a client with the appropriate level and intensity of treatment (Wallace, 1991). The assessment, developed by Operation PAR, measured 12 life domain areas including substance use, living environment, educational and employment background, economic resources, legal history, leisure activities, mental and physical health, mobility, social relationships, and activities of daily living. The assessment helped staff to determine which level of treatment was most appropriate for the client.

The goals of the clinical team were to reduce barriers and make clients feel at ease when entering treatment. A key component of this process was the establishment of an alliance between the clinician and the potential program participant. Confrontational techniques were avoided. These strategies are considered to be counterproductive when working with women (Underhill, 1986). Rather, the objective was to establish rapport, then trust.

When assisting people of color, it has been recommended that intervention workers assume an advocacy role which is aimed at bringing about equality and cultural sensitivity in service delivery (Chau, 1993). Clinicians routinely helped women to meet any immediate needs they might have, such as housing, food, or clothing, prior to administering the biopsychosocial assessment. Once rapport had been established and the clinician was viewed as an advocate rather than an adversary, the assessment was conducted. Clinical staff then met and agreed on treatment recommendations. The clinician who conducted the assessment explained the treatment recommendations to the program participant, accompanied her to the treatment facility, maintained close contact with her if she was placed on a wait list for treatment services, and for a period of four months maintained close contact once the woman enrolled in treatment should any case management or intervention needs have arisen during the initial stages of treatment. Again, intervention activities were generally aimed at problem-solving and were behavioral (outward-focused) rather than cognitive (inward-focused) and affective, a method which has been advocated when working with African-Americans (Edwards, 1982).

Since women report that they can discuss intimate matters more openly with other women (Bahna and Gordon, 1978), all team members were women of either African-American or white descent. An invaluable component of the program was a group of several intervention specialists who are recovering addicts with a record of uninterrupted abstinence. These women participate in community self-help groups and received training in providing intervention services. Due to

their personal experiences with drugs and their successful recovery, these staff members provide excellent role models for program participants and offer important linkages to community resources (Nace, 1987).

Description of Program Participants

A total of 571 women and 33 men were referred to the I-Team program during its four years of operation. Of these 604 individuals, 472 (78%) were mandated to treatment by the courts or the Florida Department of Health and Rehabilitative Services. A total of 546 individuals met the criteria for program services. Of these 546 individuals, 277 (50.7%) were African-American, 185 (33.9%) were white not of Hispanic origin, 7 (1.3%) were of other racial origin, and 77 (14.1%) were of unknown racial origin. The mean age of the 546 individuals was 26.4 years of age (range 13 - 42). The age of 15 individuals was unknown.

The majority, 354 (64.8%) of the 546 individuals had never been married. The mean number of children was 2.54 (range 0 - 10). The number of children was unknown for 48 of the individuals. The primary drug of choice for 302 (58.6%) of those individuals referred was cocaine. Alcohol was the drug of choice for 88 (16.1%) of those referred, and marijuana was the primary drug for 85 (15.6%) individuals. Three (.5%) individuals used other primary drugs, and for 50 (9.2%) individuals the primary drug was unknown.

Of the 546 individuals appropriately referred to the program, 365 (66.8%) received assessment services and were referred to treatment. Of the 365 individuals assessed by the I-Team, 214 (58.6%) enrolled in treatment services. While this figure may seem low to those outside the treatment field, it is important to compare the enrollment rates of individuals who received up-front intervention and case management services to the enrollment rates of individuals who were referred directly to a program without any assistance. This comparison is delineated below.

There were no significant differences in age at time of referral between those individuals who were assessed (mean = 26.7 years of age) and those who were not (mean = 25.9 years of age). However, older individuals were significantly more likely to be mandated to treatment ($F = 4.7$, $p<.01$). There were significant differences ($F= 23.58$, $p<.001$) in age at time of referral to the program between those who enrolled in treatment services (mean age = 27.9 years) and those who did not enroll in treatment (mean age = 25.5 years).

As shown in Table 4.1, there were significant differences between African-American and white individuals in the receipt of assessment services: 81.6% of African-Americans referred to the program were assessed compared to 71.9% of white individuals. It is important to note that there were no statistically significant differences between African-American and white individuals in their legal status. Eighty-one percent of African-Americans and 77% of whites were mandated to complete treatment.

Table 4.1

Racial Composition of Individuals Assessed by the I-Team*

RACE	ASSESSED	NOT ASSESSED
Caucasian*	133 (71.9%)	52 (28.1%)
African-American	226 (81.6%)	51 (18.4%)
Other	6 (85.7%)	1 (14.3%)
Unknown	0	77 (100%)

*($p<.01$, chi square statistic)

Nearly 51% of African-Americans compared to only 37.8% of whites accessed treatment services although there were no significant differences between the two groups in terms of legal status. See Table 4.2.

Table 4.2

Racial Composition of Individuals Enrolled in Treatment by the I-Team*

RACE	ENROLLED	DID NOT ENROLL
Caucasian	70 (37.8%)	115 (62.2%)
African-American	141 (50.9%)	136 (49.1%)

*($p<.005$, chi square statistic)

Table 4.3 shows that divorced individuals (92.9%) were more likely to access assessment services than single (80.2%) or married (65.5%) individuals, although divorced individuals were not more likely to be mandated to treatment. A higher percentage (84.5%) of married individuals were mandated to treatment compared to 79.1% of single individuals and 76.2% of divorced individuals. However, divorced individuals were not significantly more likely to enroll in treatment services than were single or married individuals. Of the 42 divorced individuals, 26 (61.9%) enrolled in substance abuse treatment services compared to 45.2% of single individuals and 43.1% of married individuals.

Table 4.3

Marital Status of Individuals Assessed by the I-Team*

MARITAL STATUS	ASSESSED	NOT ASSESSED
Single*	284 (80.2%)	70 (19.8%)
Married*	38 (65.5%)	20 (34.5%)
Divorced*	39 (92.9%)	3 (7.1%)
Widowed	2 (100%)	0
Unknown	2 (2.2%)	88 (97.8%)

*($p<.001$, chi square statistic.)

Individuals whose primary drug problem was identified as cocaine abuse were more likely to be assessed (76.6%) than were alcohol (67%) or marijuana (56.5%) abusing individuals (see Table 4.4). However, they were also significantly more likely ($p<.001$, chi square statistic) to be mandated to treatment. Eighty-five percent of cocaine users were mandated to treatment compared to 68.2% of individuals who had a primary problem with alcohol and 77.6% of individuals who had a primary problem with marijuana.

Table 4.4

Primary Drug of Individuals Assessed by the I-Team*

PRIMARY DRUG	ASSESSED	NOT ASSESSED
Cocaine	245 (76.6%)	75 (23.4%)
Alcohol	59 (67%)	29 (33%)
Marijuana	48 (56.5%)	37 (43.5%)

*($p<.001$, chi square statistic.)

Table 4.5 shows that individuals with a primary diagnosis of cocaine abuse or dependence were more likely (48.4%) to enroll in treatment than were alcohol (34.1%) or marijuana (27%) abusers. However, as stated previously, they were also significantly more likely to be mandated to treatment than were alcohol or marijuana abusers.

Table 4.5

Primary Drug of Individuals Enrolled in Treatment by the I-Team*

PRIMARY DRUG	ASSESSED	NOT ASSESSED
Cocaine	155 (48.4%)	165 (51.6%)
Alcohol	30 (34.1%)	58 (65.9%)
Marijuana	23 (27%)	62 (73%)

*(p<.001, chi square statistic.)

Legal status appeared to influence the likelihood that individuals would be assessed, with 71.3% of those individuals who were mandated to treatment completing an assessment, compared to only 50% of those who were not mandated to treatment (see Table 4.6).

Table 4.6

Legal Status of Individuals Assessed by the I-Team*

LEGAL STATUS	ASSESSED	NOT ASSESSED
Mandated	308 (71.3%)	124 (28.7%)
Not Man dated	57 (50%)	57 (50%)

*(p<.001, chi square statistic.)

Substance abusing women who were mandated to treatment were more likely to enroll in treatment services than women who are not mandated to treatment. It can be seen in Table 4.7 that 43.7% of the individuals who were mandated to treatment, enrolled compared to only 21.9% of those individuals who were not mandated by legal authority to enroll in treatment.

Table 4.7

Legal Status of Individuals Enrolled in Treatment by the I-Team*

LEGAL STATUS	ASSESSED	NOT ASSESSED
Mandated	189 (43.7%)	243 (56.3%)
Not Man dated	25 (21.9%)	89 (78.1%)

*(p<.001, chi square statistic.)

Of the 514 women who were appropriate referrals to the program, 347 (67.5%) were postpartum, 158 (30.7%) were pregnant, 7 (1.3%) had older children, and the pregnancy status and age of the youngest child was unknown for 2 (.4%) women appropriately referred to the program. As can be seen in Table 4.8, postpartum women were more likely (71.8%) to be assessed by the I-Team than were pregnant women (59.5%).

Table 4.8

Pregnant and Postpartum Women Assessed by the I-Team*

PREGNANCY STATUS	ASSESSED	NOT ASSESSED
Postpartum	249 (71.8%)	98 (28.2%)
Pregnant	94 (59.5%)	64 (40.5%)

*($p<.001$, chi square statistic.)

Postpartum women were also more likely (42.7%) to enroll in treatment services than were pregnant women (34.8%). See Table 4.9.

Table 4.9

Pregnant and Postpartum Women Enrolled in Treatment by the I-Team*

PREGNANCY STATUS	ASSESSED	NOT ASSESSED
Postpartum	148 (42.7%)	199 (57.3%)
Pregnant	55 (34.8%)	103 (65.2%)

*($p<.001$, chi square statistic.)

However, as shown in Table 4.10, postpartum women were also much more likely (93.4%) to be mandated to treatment than were pregnant women (46.2%).

Table 4.10

Legal Status of Pregnant and Postpartum Women Referred to the I-Team*

PREGNANCY STATUS	ASSESSED	NOT ASSESSED
Postpartum	324 (93.4%)	23 (6.6%)
Pregnant	73 (46.2%)	85 (53.8%)

*($p<.001$, chi square statistic.)

The average length of stay for the 214 individuals who accessed substance abuse treatment services with the aid of the I-Team was 177 days (range 1 - 999 days) excluding 24 (11%) individuals who were still in treatment at the end of the reporting period. For African-American women, the average length of stay was 212.4 days compared to 117.9 days for white women and 90.33 days for women of other racial origins.

Of the 214 individuals who accessed treatment services, 71 (33.2%) individuals successfully completed treatment, 111 (51.9%) failed to complete treatment, seven moved out of the area, and one was incarcerated. Of the 71 individuals who completed treatment, 48 (67.6%) were African-American and 23 (32.4%) were white. Therefore, among all individuals referred to the I-Team, African-American women were more likely to be assessed, enroll in treatment, and complete treatment than their white counterparts although African-Americans were not significantly more likely to be mandated to treatment. Eighty-one percent of African-Americans and 77% of whites were mandated to complete treatment.

Research Design

Operation PAR was interested in finding out whether women who received I-Team services were more likely to enroll in substance abuse treatment services than women who did not receive I-Team services. Since there are a variety of treatment types which are available through Operation PAR, Inc., it was decided that the research would focus on one program. The Children of Substance Abusers (COSA) program, which is an outpatient treatment program, was selected for several reasons. First, the largest number of women referred to any Operation PAR program during the years of the I-Team program was referred to the COSA program. These women were referred to COSA through the I-Team and by other referral sources. Second, the COSA program had a shorter wait list than other PAR programs serving women which made it more available to the target population than other programs. Third, the COSA program is located in an area of the county where the majority of female substance abusers who are referred to Operation PAR reside. The convenient location made it more accessible for women interested in treatment services with limited resources for transportation services.

The COSA program had the capacity to serve 60 maternal substance abusers on an outpatient basis. Women who were referred to COSA by the I-Team received a comprehensive biopsychosocial assessment, including an analysis of their substance abuse history, prior to their referral to the program by an I-Team staff member. If a woman was referred to the program by another service provider, it was her responsibility to make an appointment with the intake counselor and complete the assessment to the best of her ability prior to her first appointment. Women who were appropriate for the program, based on assessment results, were enrolled and received intensive case management services and outpatient counseling. Individual counseling, support groups, therapeutic groups, and parenting skills training were available to program participants regardless of the referral source.

Sampling

A total of 347 women were referred to COSA during the first three years of the I-Team program. Of these women, 43% (n=150) were I-Team referrals and 57% (n=197) were referred to the program by other sources. As can be seen in Table 4.11, the two groups of women did not differ significantly in racial composition. The majority of women (79%) referred to the COSA program were African-American; 80.7% of I-Team referrals and 77.7% of non-I-Team referrals to the COSA program were African-American women.

Table 4.11

Race of Women Referred to the COSA Program by Referral Source

RACE	I-TEAM REFERRALS (n=150)	NON-I-TEAM REFERRALS (n =197)
African-American	121 (80.7%)	153 (77.7%)
Caucasian	29 (19.3%)	44 (22.3%)

There were, however, statistically significant differences in age between the two groups as women who were referred by the I-Team were, on average, several years younger than women who were referred to the program by other sources. See Table 4.12.

Table 4.12

Age of Women Referred to the COSA Program by Referral Source*

MEAN AGE	I-TEAM REFERRALS (n=150)	NON-I-TEAM REFERRALS (n=197)
	28.4 Years (s.d. 5.5 Years)	30.2 Years (s.d. 5.0 Years)

*(p<.001, chi square statistic.)

Women who were referred to COSA by the I-Team were more likely to be pregnant (16%) at the time of the referral than were women who were referred to COSA by other sources (2%). See Table 4.13.

Table 4.13

Pregnancy Status of Women Referred to the COSA Program by Referral Source*

I-TEAM REFERRALS		NON-I-TEAM REFERRALS	
Pregnant	Not Pregnant	Pregnant	Not Pregnant
24 (16%)	126 (84%)	4 (2%)	193 (98%)

*(p<.001, chi square statistic.)

Measurement

To measure differences in treatment start, comparisons were made to determine if women who were referred to COSA by the I-Team were more likely to follow up with treatment recommendations by actually enrolling in the program than women who were referred to COSA by other sources. Treatment start was measured by whether or not women who were referred to the COSA program enrolled in treatment services. Independent variables of age, race, and pregnancy status were examined to determine if there were significant differences in enrollment status between the I-Team referrals and non-I-Team referrals to the COSA program in those factors.

Data Analysis

A computerized recordkeeping system was developed utilizing dBASE III Plus computer software. Records of all women referred to the program were maintained with the software.

Descriptive data such as age, pregnancy status, and race were held in cumulative summary files. The Statistical Package for the Social Sciences for personal computers (SPSS-PC) was used to perform the data analysis. Chi square was utilized to examine differences between I-Team referrals and non-I-Team referrals to the COSA program in treatment start.

Findings

It can be seen in Table 4.14 that women who were referred to COSA by the I-Team were significantly more likely to enroll in program services than were women who were referred to COSA by other sources. Seventy-one percent of women referred to COSA through the I-Team enrolled in the program compared to only 39% of non-I-Team referrals.

Table 4.14

Enrollment Status of Women Referred to the COSA Program*

	I-TEAM REFERRAL	NON-I-TEAM REFERRALS
Enrolled in Program	107 (71%)	77 (39%)
Did Not Enroll in Program	43 (29%)	120 (61%)

*($p<.001$, chi square statistic.)

This difference is especially significant among the women of African-American decent. Seventy-five percent of African-American women who were referred to COSA through the I-Team enrolled in the program compared to only 38% of African-American women who were referred to COSA through other sources. See Table 4.15.

Table 4.15

Enrollment Status of Women Referred to the COSA Program by Referral Source by Race*

Race	I-Team Referrals		Non-I-Team Referrals	
	Enrolled	Not Enrolled	Enrolled	Not Enrolled
African-American	91 (75%)	30 (25%)	58 (38%)	95 (64%)
White	16 (55%)	13 (455)	19 943%)	25 (57%)

*($p<.001$, chi square statistic.)

Discussion

It appears that the methods employed by I-Team program staff were useful in assisting women to access substance abuse treatment services. This was particularly true for African-American women. While 50.7% of the individuals appropriately referred to the program were African-American, 61.9% of those individuals who received assessment services and 66.5% of those who enrolled in treatment were African-American. Furthermore, the length of stay in treatment was longer and successful completion of treatment was higher for African-American women than for white women although African-American women were not significantly more likely to be mandated to treatment than white women.

From a review of clients who were referred to the COSA program, it appears that women who receive up-front crisis intervention and case management assistance in accessing treatment services are more likely to enroll in substance abuse treatment services than women who do not receive similar services. African-American women are thought to be more difficult to engage in substance abuse treatment services than white women based on their perceived need for treatment and other culturally salient factors identified above. Therefore, it is important to strengthen the engagement process when trying to help African-American substance abusers in accessing treatment services. The engagement process includes outreach, recruitment, referral, intake, and assessment (Longshore, et al., 1993).

Three-quarters of the African-American women included in the study who accessed I-Team services enrolled in the COSA program, whereas just over one-third of the African-American women who received a direct referral enrolled in the COSA program. Intervention programs oriented toward serving African-American women need to focus on helping the women to solve their practical, interpersonal, and psychological problems. Female African-American substance abusers appear to benefit when provided with up-front crisis intervention services designed to assist them in stabilizing their lives and becoming more aware of and familiar with treatment options. Women who access such services may also be more likely to enroll in treatment. Because of the variety of problems substance abusing women face when seeking treatment services, a program which provides "user friendly" access to needed resources may help these women get to treatment. In order to keep pregnant and postpartum substance abusers enrolled, it may be necessary to provide similar services throughout the treatment process.

Practitioners must play a non-judgemental advocacy role in order to help women access substance abuse treatment services. The client must come to view the practitioner as her advocate not adversary. This can be accomplished by assisting her with accessing any services she needs such as child care, transportation, medical care and the like. After a basis of trust has been developed, she should be given a thorough biopsychosocial assessment which measures crucial life domain areas in order to determine the level and intensity of substance abuse treatment needed. The practitioner needs to make her aware of her treatment options and often a tour of the treatment

facility prior to enrollment will help alleviate some of her fears. The intervention worker needs to maintain contact with the client and remain her advocate at least until she is stabilized in treatment.

Ideally, African-American intervention specialists should work with African-American women. For the I-Team program, this was not always possible. The program experienced some difficulties in recruiting African-American clinicians. At one time, only 60% of staff were African-American women. It is crucial, however, that women assist women in accessing substance abuse treatment services as men are often viewed as the perpetrators of the sexual and physical abuse so many substance abusing women have experienced (Burman, 1992). One satellite office hired two white male clinicians and both were extremely unsuccessful in developing a rapport with potential program participants. In fact, many women, both African-American and white, did not answer the door when the men attempted to conduct a home visit to complete the assessment.

The intervention model proposed is based on the I-Team clinicians' experience in treating African-American women whose primary drug of choice was crack cocaine, alcohol, or marijuana. It is not expected that the I-Team model will be applicable to all situations and/or all ethnic/racial groups. However, the I-Team learned that, in general, in order for treatment to be effective for anyone, it must build on the knowledge base and world view of the program participant. If the treatment is not relevant to the program participant, if she cannot relate to it based on what she knows about the world, it will not be useful to her and the clinician or practitioner may as well be speaking to her in a foreign language. It is equally important that the practitioner know the community or neighborhood in which the target population resides. Each community, regardless of income level, has a wealth of resources available to help women meet their service needs and access substance abuse treatment services. It is crucial that workers know the resources that are available and how to access them. It is also important that intervention workers be familiar with drug trends in their area and the street names for those drugs.

> *Personal Note from L.M.:* This author is convinced that the best place to interview a woman is at her kitchen table. She is likely to feel more comfortable there than in your office or in her own living room. If you can get her alone in her own kitchen, you will find out more about her than you would in any other setting.
>
> *Personal Note from S.D.:* What is needed is early intervention. With intervention these mothers and their children can be successful. We must have high expectations for their success and rehabilitation.

References

Angelou, M. (1993). Wouldn't Take Nothing for My Journey Now. New York: Random House.

Bahna, G., Gordon N.B. (1978). Rehabilitation experiences of women ex-addicts in methadone treatment. The International Journal of the Addictions, 13(4), 636-655.

Bell, P. (1993). Black and recovering: My search for identity. Minnesota: Johnson Institute.

Boyd, C. J. (1993). The antecedents of women's crack cocaine abuse: Family substance abuse, sexual abuse, depression and illicit drug use, Journal of Substance Abuse Treatment, 10, 433-438.

Burman, S. (1992). A model for women's alcohol/drug treatment, Alcoholism Treatment Quarterly, 9 (2) 87-99.

Butler, J.P. (1992). Of kindred minds: The ties that bind. In M.A. Orlandi (Ed.), Cultural competence for evaluators (pp. 23-54). Rockville, MD: U.S. Department of Health and Human Services.

Center for Substance Abuse Prevention. (1993). Adapting traditional alcohol and other drug recovery programs to meet the needs of women and their families. Healthy Delivery, 1(3), 1-5.

Chasnoff, I.J. (1993). Women and addiction: Why/how are they special? Addiction Treatment Forum, 2, 1, 5.

Chasnoff, I. J. (1990). The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas, County, Florida, The New England Journal of Medicine, 322(17), 1202-1205.

Chau, K.L. (1993). Needs assessments for group work with people of color: a conceptual formulation. Social Work with Groups, 15(2/3): 53-66.

Chestang, L. (1972). Character development in a hostile environment. Chicago: University of Chicago Press.

Craig, R.J. (1987). Clinical management of substance abuse programs. Illinois: Charles L. Thomas.

Dalton, H. (1989). AIDS in blackface. Daedalus, Journal of the American Academy of Arts and Sciences. Living with AIDS: Part 2, The American Academy of Arts and Sciences. 118(3): 205-227.

Edwards, A.W. (1982). The consequences of error in selecting treatment for blacks. Social Casework, 63(7): 429-433.

Eldred, C.A., Grier, V.V., & Berliner, N. (1974). Comprehensive treatment for heroin-addicted mothers. Social Casework, 55(8), 470-477.

Eriksen, L. (1986). The effect of waiting for inpatient alcoholism treatment after detoxification: An experimental comparison between inpatient treatment and advise only. Addictive Behaviors, 11, 389-397.

Freier, M.C., D.R. Griffith, & Chasnoff I.J. (1991). In utero drug exposure: Developmental follow-up and maternal-infant interaction. Seminars in Perinatology, 15(4), 310-316.

Gehshan, S. (1993). A step toward recovery: improving access to substance abuse treatment for pregnant women. Washington, DC: Southern Regional Project on Infant Mortality.

Grace, C.A. (1992). Practical considerations for program professionals and evaluators working with African-American communities. In M.A. Orlandi (Ed.), Cultural Competence for Evaluators (23-54). Rockville, MD: U.S. Department of Health and Human Services..

Green, J.W. (1982). Cultural awareness in the human services. New Jersey: Prentice-Hall, Inc.

Grenier, C. (1985). Treatment effectiveness in an adolescent chemical dependency treatment program: A quasi-experimental design, International Journal of Addictions, 20, 381-391.

Hailer, D.L. (1991). Recovery for two: Pregnancy and addiction, Addiction and Recovery, 11, 14-18.

Katz, R. (1963). Empathy: Its nature and uses. Illinois: Free Press.

Kleber, H.D. (1993). Treatment improvement protocol on screening, assessment, and treatment planning for patients with concurrent dependency on opioids and stimulants. Washington, DC: Center for Substance Abuse Treatment.

Kumpher, K.L. (1991). How to get hard-to-reach parents involved in parenting programs. In Parent Training is Prevention (ADM 91-1715). 87-95. Washington, DC: U.S. Government Printing Office.

Lex, B.W. (1991). Some gender differences in alcohol and polysubstance users. Health Psychology, 10(2), 121-132.

Longshore, D., Hsieh S. , & Anglin M.D. (1993). Ethnic and gender differences in drug users' perceived need for treatment, The International Journal of the Addictions, 28(6), 539-558.

Marsh, J.C., & Miller N.A. (1985). Female clients in substance abuse treatment, International Journal of the Addictions, 20, 995-1019.

Miller, W.R. (1992). The effectiveness of treatment for substance abuse, Journal of Substance Abuse Treatment, 9, 93-102.

Nace, E.P. (1987). The treatment of alcoholism. New York: Brunner/Mazel.

National Institute on Drug Abuse. (1979). Addicted women: Family dynamics, self perceptions, and support systems. Rockville, MD: Services Research Branch.

Perez-Arce, P., Kirkland, D.C. , & Sorensen J.L. (1993). Cultural issues in an outpatient program for stimulant abusers, Journal of Psychoactive Drugs, 25(1): 35-44.

Ravndal, E., & Vaglum, P. (1992). Different intake procedures: The influence on treatment start and treatment response - A quasiexperimental study, International Journal of Addictions, 9, 53-58.

Reed, B., & Moise,R. (1987). Implications for treatment and future research. In Addicted Women: Family Dynamics, Self Perceptions and Support Systems (ADM 80-762). Washington, DC: Department of Health, Education and Welfare.

Richmond, J.B. (1991). In S.S. Brown (Ed.), Children and parental illicit drug use: Research, clinical, and policy issues summary of a workshop (pp. 12). Washington, DC: National Academic Press.

Robinson, J.B. (1989). Clinical treatment of black families: Issues and strategies, Journal of the National Association of Social Workers, 34(4), 323-329.

Smith, D.E., Buxton, M.E., Bilal, R., & Seymore, R.B. (1993). Cultural points of resistance to the 12-step recovery process, Journal of Psychoactive Drugs, 25(1), 97- 108.

Thompson, M., Ellis, M., & Wildavsky, A. (1990). Cultural theory. Colorado: Westview Press.

Underhill, B.L. (1986). Issues relative to aftercare programs for women, Alcohol Health and Research World, 11(1), 46-47, 73.

Vannicelli, M. (1984). Barriers to treatment of alcoholic women, Substance and Alcohol Actions/Misuse, 5, 29-37.

Wallace, B.C. (1991). Crack cocaine: What constitutes state of the art treatment? Journal of Addictive Diseases, 11(2), 79-95.

Wildwind, L., & Samson, S. (1981). The process of counseling drug dependent women. In G.M. Beschner, B.G. Reed, and J. Mondanaro (Eds.), Treatment Services for Drug Dependent Women (NIDA Treatment Research Monograph No. 1, 109-163). Rockville, MD: National Institute on Drug Abuse.

Chapter 5

WHEN CHILDREN'S NEEDS TRANSCEND CULTURAL DETERMINANTS

Jean Adnopoz, MPH, Tracy Washington, MSW
Steven Nagler, MSW, Wendyann Wyatt, MSW
Family Support Services
Yale University Child Study Center

Introduction

Basic Needs of All Children

The influence of culture and ethnicity have been recognized by numerous authors as potent factors in the formation of character and self identity (Axelson, 1993; Devore & Schlesinger, 1991; Lum, 1992; Sue & Sue 1990). Membership in a specific ethnic group carries with it both internal and external characteristics, beliefs and expectations which play a role in shaping the lives of those in the group. When these characteristics are seen as stereotypical rather than understood and respected they not only demean the individual and the larger culture, they may lead to a range of inappropriate behaviors and responses by persons from outside the group which perpetuate the attitudes which have not been helpful in addressing the problems of the affected group.

This chapter attempts to inform and enhance work with substance abusing women and children by increasing the ability of service providers to understand the effect of ethnicity and culture on treatment and intervention choices. This chapter will specifically focus upon the universal needs of all children during the early years of life within the context of cultural differences. The central thesis to be presented is that every child enters the world a helpless being completely dependent upon adult caregivers to meet his/her physical and psychological needs. The importance to the individual child of the satisfaction of these critical basic needs transcends cultural and ethnic differences, although the cultural context may profoundly influence the particular way in which adults meet the child's demands and perform specific caregiving tasks.

For the past decade, programs designed to serve substance abusing women have proliferated in the United States and elsewhere. Because it has been widely recognized that a substantial number of these women are also mothers who are responsible for the day-to-day care of their children, a number of these programs attempt to address the needs of children as well. Abstinence and relapse prevention are frequently the central focus of drug treatment programs;

issues arising from taking on the responsibilities and challenges of parenting are not seen as central to the work of treatment and recovery. However, just as all children have certain basic needs which must be met if the child is to move forward developmentally, (Goldstein, et al., 1996) and others believe that parents have needs as well, which when addressed, increase their ability to feel competent in the role of parents. Supporting substance abuse affected families in caring for their young children may not only result in improved outcomes for vulnerable children, but may prove to be an effective means of moving the substance involved adults towards less risky and self destructive behaviors. Providing intervention within a family setting may also ensure that the cultural context is acknowledged and respected.

Factors Which Place Children at Risk

At the present time, large numbers of children are at risk for poor outcomes including prematurity and low birth weight, as a result of parental substance abuse and/or HIV infection, a disease found among drug users because of the ease of transmission through needle sharing or unprotected sexual activity with an infected partner (Kusserow, 1990). Crack-for-sex exchanges are of particular concern because of the higher risk for unprotected contact (Edlin et al., 1994). Drug use among pregnant women is not uncommon. Two million of the estimated 5 million Americans who use cocaine regularly are estimated to be women of childbearing age (Gustavson, 1992).

A 1989 survey in an obstetrical clinic in New Haven, Connecticut, found that 90% of the women who received no prenatal care prior to presenting for delivery had used drugs during their pregnancy; more than 50% of this group were HIV positive. Another survey, completed during that same year, found that of a total of 383 women admitted to a local hospital for labor and delivery during a one-month period, 36 (9.4%) reported using cocaine during pregnancy. Many researchers have found that women who use cocaine regularly during pregnancy tend to be poor, unemployed, single, and have less than a high school education (Gustavson, 1992; Chasnoff, et al., 1985). They frequently have histories of trauma, and have been alienated from their families of origin.

Mothers are frequently clinically depressed or chronically, psychologically depleted. For some, drug use is initiated as an attempt at self-medication in the service of coping with feelings of low self-esteem, a lack of self-confidence, and a diminished sense of opportunity and hopefulness (Adnopoz & Nagler, 1992). As the result of the complex interweaving of these demographic and psychological factors including poverty, minority status and racism, adolescent parenthood, homelessness, joblessness, chronic mental illness, drug use, and the lack of adequate resources to purchase commodities such as nutritious food, adequate housing in relatively safe environments, medicine and appropriate safety devices, these women and their children are vulnerable for a range of negative outcomes.

The association between maternal drug use and other complications of delivery and postnatal care have been well documented (Johnson and Rosen, 1990). Children from drug-involved families are over-represented in the child welfare system. Most of the children in foster care in this country today come from families in which poverty, low educational status, and inadequate social support are hallmarks. Many of these children have reactive emotional and developmental problems which are often exacerbated by their removal from their families and the disruption of their primary ties. The threat of removal of children from their families because of the mother's chemical dependence may not only cause considerable harm to the child's ability to develop meaningful relationships with others, it may also impact negatively upon the mother's willingness to seek medical care during her pregnancy or to enter into drug treatment once the child is born (Gustavson, 1992).

In addition, mothers who experience considerable stress and depression are less likely to be free to interact expressively with their children. Repeated clinical observations have also demonstrated that some mothers from psychologically deprived environments lack the capacity for play. These women are often unable to enter into interactions with their children which are stimulating, imaginative, or curiosity promoting.

Linda Mayes and others of the Yale Child Study Center, who are following a cohort of children born to women who used cocaine during pregnancy (as well as a group of children born to non drug-using mothers), have found that the drug-affected children have significant problems in the area of language development and attention (Malakoff, et al., 1994; Mayes, et al., 1996; Mayes and Bornstein, in press). Children who are affected by stressors such as poverty and parental drug use have more mental health and emotional problems than wealthier children and have higher percentages of learning disabilities (Klerman, 1991). Other researchers have found that approximately 2/3 of all children who test mildly retarded have grown up in poverty. Poor children whose parents live in social isolation without social support and who are at risk for using illegal substances are more likely to show decreased cognitive ability, behavior problems, and lower I.Q. These children also suffer disproportionately high rates of problems related to nutrition, asthma, otitis media, and other infectious diseases, as well as increased incidence of dental decay and lead poisoning.

Many parents who are active substance users have given up, overwhelmed by their inability to control their environment, unable to imagine themselves or their children making it in an increasingly violent and hostile world. Their sense of powerlessness, frustration, sadness, and longing is often pervasive. The struggle in which these parents engage in daily in order to survive often exacerbates those feelings and behaviors which lead to bad parent and child outcomes. Increased depression and social isolation, more frequent use of drugs and alcohol, suicidality, lack of medical compliance, and child abuse and neglect may result (Forsyth et al., 1992). However, large numbers of children grow up in poor families and become healthy, well functioning adults. Their experiences, combined with knowledge of the psychological and

developmental needs of children, teach us much about those factors which mediate and protect against adverse outcomes.

Supporting Families to Care for Children

Two assumptions can be used to guide the work with vulnerable children and their families. The first is that children are most appropriately cared for within the context of a consistent, loving family; the second postulates that the majority of parents wish to be adequate caregivers for their children. Many parents, particularly those who are drug-involved, lack the family and community supports necessary to regularly engage with their children in positive, health promoting ways. Nonetheless, they do care about their children and are likely to respond to offers of assistance when the offers are experienced as respectful and accepting of them.

For children in substance-affected families with multiple stressors, optimal care may be an unreasonable goal. However, it is the search for the least detrimental alternative for the affected children which should inform our thinking and shape our interventions. The authors believe that home-based treatment provides a unique opportunity to understand the family, assist parents to identify their needs, and mobilize their resources by building upon their strengths, not the least of which is the richness of their own culture and history.

The Universal Needs of Children and Parents

Attachment and Developmental Stages

The need of all children for consistent, nurturing relationships with the adults who care for them has been addressed by Anna Freud and others (Freud, 1930; Goldstein et al., 1996). These all-important relationships provide the means through which each child's need to be loved, protected from danger, and to feel unique or special can be met. When parents or other adult caregivers are not available to the child consistently, the child's ongoing development may be put in jeopardy. Children whose parents are removed from them, but who are not placed permanently with a family committed to their care, may experience the psychological distress of multiple placements which may impact negatively on their ability to experience positive, loving relationships with others throughout the life cycle.

Bowlby (1988), in his studies of children separated from their mothers, found a specific chain of reactions in the disruption of parent/child attachment which included protest, despair, and detachment (Spencer, 1983). The Robertsons (1969), in their case study of a toddler who experienced multiple caregivers when placed in an institutional setting during his parent's absence, graphically documented on film the increasing regression and disorganization of their subject.

A dissenting view has been expressed by Kagan and other researchers, who question whether there are universal outcomes from early parental experiences which persist throughout the life cycle. These researchers believe that children may still develop the capacity for intimacy if they are provided a nurturing and consistent environment during their formative years, and not necessarily from birth (Kagan, 1980). However, there is agreement that eventual continuity and consistency of caregivers provides each child with the stability and predictability which is essential for his/her developmental progress.

Children who are affected by parental substance use or by HIV infection have the same deep psychological needs for continuity of care, for affection, for belonging, for a sense of family culture and history as all other children. However, without the support of others, including extended family members, members of their social network, and service providers, their parents may have difficulty responding to this need.

Although all parents would probably like to be supported by their families and their community, and to be recognized as competent in the parental role, drug-affected parents frequently report receiving very little positive reinforcement for their parenting behaviors. In fact, drug-involved parents may, indeed, have periods of time when they are able to function only marginally in the parental role. They may have difficulty living without drugs, binge on occasion, suffer from depression, be unable to maintain long-term, positive relationships with significant others, get in trouble with the law, and have periods of time when they are not physically able to provide child care. Even when they are willing to enter into treatment for their substance use, they may be subject to relapse.

Recent studies have found that mothers' perceptions of the responsiveness of their infants to mother/child interactions may affect the nature of these interactions. Mothers' perceptions were affected by their own internal state and level of functioning, as well as the behavior of their infants (Johnson & Rosen, 1990). Substance using mothers, like others under stress, may have difficulty separating their own internal states from those of their children. Some mothers express doubt, guilt, and anxiety about the effect of their lifestyle and drug use on their offspring. Some mothers also have such a low sense of adequacy and self-esteem that they contemplate placing the child with someone they believe is more competent even though they love and want the child. Attempts to meet parents' needs for validation and support may help them to recognize their importance to their children and the positive influence which they potentially can exert on all aspects of their child's development. As a result, parents who feel supported may become more available to meet their children's needs and to satisfy the deep longing that each child has to be loved by his/her mother.

The Family as Transmitter of Culture and Values for Children

The Universal Role of the Family

Bronfenbrenner (1976) has described the family as "the primary and proper agent for making human beings human." Families provide safe, nurturing environments in which children are able to grow physically, mentally, and emotionally, to explore their world, to establish their historical identity and gain a sense of belonging, not only to their immediate and extended family but also to

their ethnic and cultural past, and learn the skills necessary to negotiate the world around them. In this environment the child is able to feel wanted and important, and this leads to a sense of comfort, identity, and possibility (Provence, 1979). Families also provide guidance, stimulation, and limit setting, which leads children to explore their world safely, to expand their understanding of that world through imagination and play, and to gain a sense of being cared about and protected from danger. Families interpret the world for children, transmit their values and beliefs, offer assistance and support, and serve as havens of relief from crisis and distress.

The Role of the Family in Cultural Transmission

The cultural values and/or ethnicity of the family mediates its interaction with the external world (Pinderhughes, 1982). African-American families may transmit values such as collectivity, sharing, affiliation, obedience to authority, belief in spirituality, and respect for the elderly and the past. Hispanic/Latino values may include respect for authority, the importance of self-respect, a belief in spirituality, the control of aggression, and respect for the family's unity, welfare and honor (Garcia-Preto, 1982). American values may emphasize individualism, independence, autonomy, materialism, achievement, mastery, progress, youth, future orientation, efficiency, and planning. Accepting and respecting the multiple value systems of an individual family is a tangible means of providing support to families and assisting them in their child rearing tasks.

Cultural Differences Influencing Family Function

At the current time, minority families are over-represented among families affected by parental substance abuse (Report to Congress on Abandoned Infants, 1994). These families often struggle with issues of powerlessness and racism which have influenced the development of group cohesion and prevented the establishment of accepted guidelines for managing power and negotiating conflict (Pinderhughes, 1982). The matriarchal role of African-American women has both adaptive and maladaptive elements which may undermine the position of the male adult and leave the male child unprepared to play a positive role in the multicultural environment of the larger society. Some observers have found that in families where the male in so undermined in his role, he may appear as irresponsible, manipulative, remote, or violent. In these families, if the

mother is unable to play a strong, constructive role, the family may face real difficulty (Pinderhughes, 1982). Such situations may have long-term negative developmental implications for children unless appropriate intervention takes place.

In contrast, Hispanic/Latino families are traditionally patriarchal; machismo is a prized attribute, and women are expected to be the sole child caregivers. The authority of the husband is not openly challenged. Children, like their mothers, are expected to be docile, obedient, and respectful. Families have limited expectations of infants and toddlers, and do not recognize their individuality. Both African -American and Hispanic/Latino families commonly use physical punishment, believing that children will be "spoiled", disrespectful, or unprepared for the rigors of life if they are not exposed to physical punishment (Garcia-Preto, 1982). Grant cautions professionals to avoid generalizations in assessing use of corporal punishment. She suggests that family income has a differential affect on disciplinary practice across all races and ethnic groups and that careful assessment must be conducted before concluding that corporal punishment is used simply because a family is African-American or Hispanic/Latino. These families believe that they are preparing their children for the difficulties they will face in the predominantly white, mainstream culture (Grant, 1993).

In both African-American and Hispanic/Latino groups, extended families often supplement the parents' caregiving efforts and children may have significant relationships with several adults (Garcia-Preto, 1982). These relationships are frequently not made explicit, in part because they are so regularly experienced, but also because parents worry that if these arrangements are known to intervenors, such as child welfare workers, they will put the custody of their children in jeopardy.

Although value preferences, beliefs, and patterns of child rearing vary markedly between and among cultures and ethnic groups, children throughout the world attain normal maturational and developmental milestones within each culture or group. In healthy family units, each child is able to extract what he/she needs to feel wanted, cared for, and protected, regardless of the means by which that is expressed, so long as the caregivers are predictable, protective, and consistent over time. The resilience of children and the push towards health help the vast majority of children to reach adulthood able to function adequately, despite a pile of stressors in the case of parental alcoholism and/or drug addiction.

However, when a major societal problem such as drug use, with its associated issues of poverty, racial and ethnic discrimination, inadequate housing, unemployment, under-education, lack of opportunity, and despair affects the functioning of a family unit, the outcomes for children are threatened and some children are placed at serious risk.

HIV-Affected Children and Families

Drug-Addicted Women at High Risk for HIV Infection

Drug-addicted women and their children are at increased risk for HIV infection. A recent report of the Abandoned Infants Assistance Programs (1994) notes that the substance using women served in the 38 funded programs in the United States were 100 times more likely to be infected with the immunodeficiency virus (HIV) than women of childbearing age in the United States overall.

It has been estimated that between 55,000 and 75,000 women in the U.S. will have been diagnosed with AIDS by the end of 1994 (Geballe, Gruendel, & Andiman, 1995). More than 95% of these women will contract the disease either through their own intravenous (IV) drug use or sexual relations with an IV drug user. Although it is expected that 7,500 infants will be exposed to the disease perinatally, the majority of these children will not be infected themselves. With increased prenatal administration of AZT, the number of children who are actually HIV-infected appears to be shrinking. However, the number of those children who will be affected by HIV and AIDS continues to grow. Some researchers estimate that approximately 24,600 children and 21,000 adolescents are expected to be orphaned by AIDS because of the deaths of their mothers in the next year (Levine, 1995). Others suggest that by the year 2000, 125,000 children will be left motherless by this epidemic (Geballe, Gruendel, & Andiman, 1995). AIDS will leave more children motherless than motor vehicle accidents or cancer (Michaels & Levine, 1992).

Issues Facing HIV-Affected Children

Because HIV infection has been closely linked to poverty, drug use, homosexuality, and minority status, initial societal responses to infected persons were rejection and ostracism. Underlying this reaction was a lack of education about the disease, fear of contamination, and deep discomfort with the issues it raised of sexual behaviors and their consequences. As a result, those who are affected by the disease, especially in the heterosexual, minority community, frequently employ secrecy and withdrawal as a coping strategy, and are often unwilling to share the secret of their illness even within the intimacy of their family. This situation can lead to parental behaviors and attitudes which further complicate the experiences of children affected by their parents' or siblings' illness.

Families affected by HIV must inevitably confront the loss of their family members through death. Unfortunately, at a time when the support of others could be most helpful in coping with the process of mourning and separation, the family often remains isolated and feels itself ignored and unworthy. For children, these events can leave them feeling guilty, confused, uncertain about their future, and without permission to name the potent family secret which has alienated them from their community and in some cases, from their extended families as well.

Interventions

Barriers to Treatment

Interventions with substance abusing, multi-problem families face many potential barriers. Some families may be resistant to any intervention, wary of outsiders, particularly those who come from cultures, races, or socioeconomic groups other than their own and from whom they feel alienated. Services may be inaccessible, especially for parents who must use public transportation, travel with several small children, and who have no other resource for child care. Language barriers may impede communication. Caregivers may have little knowledge or appreciation of cultural differences, customs, or strongly held beliefs. The service system may not recognize the family's strengths and may blame the family for the difficulties confronting it. The system may fail to understand how it is experienced by the family and the extent to which its authority threatens, demeans, and disempowers family members.

New Paradigms for Service Delivery

In August, 1993, the United States Congress enacted a new Subpart 2 of Title IV-B of the Social Security Act entitled Family Preservation and Support Services (Omnibus Budget Reconciliation Act of 1993). Subpart 2 is the first major change in Title IV-B since the landmark Adoption Assistance and Child Welfare Act of 1980 which required that states make reasonable efforts to prevent the removal of children from their parents into foster placement or institutional care. In the years since 1980, a large number of home-based, family support programs have been developed in the United States which rely upon home visitors, in-home clinicians, and/or clinical teams to mediate crises, identify problems, assess family needs, access necessary and appropriate services, and develop plans of intervention with the goal of maintaining vulnerable children within their families. These interventions are designed to build parental competencies and be responsive to the family in its own culture and environment. Services are expected by the federal government to promote the nurturing capacities of parents by stress reduction, the creation of supportive networks, and the reduction of social isolation. To be successful, service providers must respect each family with whom they work and accept their current level of functioning.

The Family Preservation and Support Act looks to states and local communities to enter into new collaborations with public and private agencies and systems which will represent a comprehensive and integrated approach to families and through which the program's goals will be accomplished. Education, health, mental health, courts, police, and other entities are encouraged to come together to develop innovative responses to the complex, multi-layered needs of vulnerable families.

A Model of Home-Based Family Support

The Mother's Project/Family Support Service is a 24-hour, in-home, voluntary program for

families in which a child is at risk of being removed from the home because of the mother's substance abuse. The program joins child mental health and adult substance abuse treatment providers in an integrated approach to strengthening families while also addressing the treatment needs of the substance using parent. The goals of the program are to reduce drug dependency and assist the family to maintain the child safely within the family environment. The specific goals for each family are set by the therapeutic team and the family.

The program is staffed by trained, crisis-oriented family support workers who join with social work clinicians to form a therapeutic team, a modality which is particularly well suited to meeting environmental, concrete, and intrafamilial needs of clients. The work of the family support worker takes place in the home and the community; more traditional treatment directed towards abstinence and relapse prevention is provided at a day treatment site which also offers child care. Additionally, the program has the capacity to offer child evaluations and assessments in the home.

The lay family support worker, a role model with whom families can identify, works within the family, shares their language, and accepts their lifestyle without being judgmental. He or she is an essential element in the intervention, lending support, respect, and ego strength, and reducing the distrust and isolation that has characterized many of the adults' previous relationships. The relationship which develops between the family support worker and the mother is seen as the primary means of changing negative behaviors and moving towards health. This therapeutic alliance may be a mother's first experience of trust and acceptance.

The in-home intervention also may help the family to make better use of the drug treatment facility and the resources available within the community by supporting the mother's involvement in treatment, helping her to overcome resistance, and maintaining a focus on the benefits which will accrue to her child if she is able to meet her child's needs. Because it operates within a context of accepting and respecting cultural, ethnic, and lifestyle differences, the team structured, in-home, family support model holds promise for being an effective intervention with families at high risk for poor outcomes for children.

The Shared Parenting Program

The Shared Parenting Program was developed as an intervention for children affected by HIV or parental drug use who cannot be cared for exclusively by their biological parent. This program was designed to meet the developmental need of all children for permanency and belonging by building upon the childcaring relationships that exist naturally in some cultures within extended family networks. Staff members assist terminally ill parents to plan for the temporary care of their children when they are too acutely ill to provide care themselves, and for permanent placement after their inevitable death. The program attempts to reduce the discontinuity of placement by helping the parent to identify one particular family that will be both the temporary and permanent resource for the child. The program also provides support and assistance to the surrogate family to minimize the disruption, loss, and separation experienced by the child and to

maintain the attachment to the biologic parent. The program also has attempted to address some of the legal problems inherent in the transfer of guardianship.

Case Vignette

An illustration of the ways in which family support and shared parenting interventions can be integrated to serve the best interests of the child:

Christopher was 16 months old and his half-sister Myra was 15 years old when they were referred to the Yale Program for Children and Families Affected by AIDS. Christopher and his mother Elizabeth were HIV-infected. Myra was not. When Elizabeth was too sick to care for him, Christopher was cared for in his home by Myra; and in the homes of his aunt Karen (age 36); and by aunt Norma (age 27). His aunts lived in different apartments in the same housing project as Elizabeth.

Both Christopher and Myra were referred for a mental health evaluation by a hospital AIDS care program. Myra appeared depressed and Christopher under-stimulated. At the time of referral to the program, Elizabeth had not told Myra about her infection or Christopher's. Although the need was immediately apparent from the referral information, it took more than 6 months of home-based clinical casework to prepare the way for a developmental evaluation of Christopher and a psychological evaluation of Myra. First, Elizabeth had to be sure that the clinical team would accept her and her family. This assurance came first by way of concrete services that were provided to or arranged for the family including: food, formula, diapers, clothing, and help with income assistance, rent support, and utility support programs. It also came through the persistent, committed, and accepting efforts of the clinician and family support worker team to engage with the family in the children's interests. Numerous times a member of the clinical team would go to Elizabeth's apartment for a scheduled appointment only to be told to come back some other day. Almost as many times, a team member would knock on the door and no one would answer, whether or not anyone was actually home. Despite these barriers, the team persisted in trying to gain Elizabeth's trust.

After 6 months of intervention, Elizabeth had not spoken directly to Myra about her diagnosis or about Christopher's. The clinician felt certain that Myra "knew" and she talked with Elizabeth about this on several occasions. Elizabeth had not spoken with her sisters, either. In fact, her sister, Karen, who was also HIV-infected had not told Elizabeth of her own status. Following one of several hospitalizations during the first year of intervention, Elizabeth informed the clinician that she wanted to tell Myra about her infection. This came shortly after she told the clinician about a dream she had in which Myra found out about her mother's infection only after Elizabeth's death. "Then she'll be sorry for the way she treated me," Elizabeth said.

The next several sessions between Elizabeth and her clinician focused on preparing to tell Myra about her infection. After careful planning - even role playing the scenario with Elizabeth - a time was set for the clinician to be with Elizabeth when she told Myra. The day and time arrived. Elizabeth was home waiting when the clinician arrived. She said that she was ready to tell Myra. However, soon after Myra came home, Elizabeth suddenly became enraged and began a fierce argument with her daughter about an unrelated minor misbehavior. It was as if Elizabeth became acutely angry so that she could hurl her diagnosis at Myra in a single breath; as if that was the only way she could get it out. Myra ran out of the apartment.

Following this episode, and continuing through many sessions with the clinician and family support worker, Elizabeth and Myra slowly began to acknowledge their fears to each other. Elizabeth eventually permitted psychological evaluations of both Christopher and Myra. Christopher was found to be on a generally normal developmental trajectory and to be closely attached to his mother, his sister, and his aunts. He was referred to an early intervention program which provided transporation for him and his four caretakers. During the times that Elizabeth was hospitalized, she continued to be cared for by Karen on certain days and by Norma on others. Myra was often responsible for him in the afternoons, even when her mother was home and well enough to assume her role as primary parent. With Elizabeth's help, the clinical team established working relationships with the entire family which supported the continuity of Christopher's care.

Myra's psychological testing and evaluation was begun by a psychologist in Myra's home and completed at the outpatient mental health clinic. Myra was found to be a pseudo-mature, moderately depressed teenager who felt overwhelmed by her current child care responsibilities for Christopher and by her anxiety regarding her mother's eventual death. Following the evaluation, she accepted the idea of a referral for individual psychotherapy. She asked that her therapist be the same clinical caseworker who had been working with the family for almost a year, and that the treatment occur in the home in part because she was unsure of her aunts' availability and was reluctant to leave her brother. Following the start of her treatment, Myra began attending school regularly for the first time in two years. In addition to her home-based individual treatment, she began attending a support group for un-infected teenagers in AIDS-affected families, also provided by the Yale Program.

This case illustrates the importance of acceptance, persistence, patience, and timing on the part of those working with the children and families affected by factors such as parental substance abuse and HIV infection.

Conclusion

The ability of treatment providers to meet the developmental needs of children affected by parental substance use through direct, child-focused service and a range of treatment modalities for parents who are active drug users, is dependent upon the ability of the programs to sensitively engage a group of women who are among the most difficult to reach. The process of engagement is complex, varies from individual to individual, and is not yet fully understood by providers. For many women, the interweaving of multiple, chronic environmental stressors, depression, and discrimination have led to despair and surrender. Breaking through these issues requires commitment, time, and patience.

It does appear that some women are more likely to respond to interventions targeted initially towards their children or their parental role than to interventions focused upon their own treatment, suggesting that interventions which build upon the wish of the great majority of parents to be competent parents may be more likely to succeed. Engagement should involve not only the parents and child(ren) within the nuclear family but also others in the extended family, and social network. In this context, knowledge, understanding, and respect for diverse cultural patterns and practices will be intrinsic to success.

References

Adnopoz, J.A., & Nagler, S.F. (1992). Supporting HIV infected children in their own families through family centered practice. In R. Grigsby & S. Morton (Eds.). Advancing family perservation practice, (pp. 119-128). Newberry Park: Sage Publications Inc.

Ahart, A., Rutsch, C., Morgan, C.H., & Kotler, M. (1991). Programs serving drug-exposed children and their families (Submitted to the U.S. DHHS, Contract No. HHS1 00-87-0039). Washington, DC: Macro Systems, Inc.

Axelson, J.A. (1993). Counseling and development in a multicultural society. Pacific Grove: Brooks/Cole.

Bowlby, J. (1988). A secure base: Parent-child attachment and healthy human development. New York: Basic Books.

Bronfenbrenner, U. (1976). Who cares for America's children? In Vaughn & Brazelton (Eds.) The family--can it be saved? Chicago.

Chasnoff, I.J., Burns, W.J., Schnoll, S.H., & Burns, K.A. (1985). Cocaine use in pregnancy. New England Journal of Medicine, 313, 666-669.

Devore, W., & Schlesinger, E.G. (1991). Ethnic-sensitive social work practice (3rd. ed.). New York: Merrill of Macmillan Publishing.

Edlin, B., Irwin, K., Faruque, S., McCoy, C., Word, C., Serrano, Y., Inciardi, J., Bowser, B., Schilling, R., & Holmberg, S. (1994). Intersecting epidemics: Crack cocaine use and HIV infection among innner-city young adults, New England Journal of Medicine, 331(21), 1422-1427.

Forsyth, B.W.C., Adnopoz, J., & Nagler, S.F. (1992). AIDS in childhood. In P.J. Wilner (Ed.), Psychiatry, (pp. 1-13). Philadelphia: J.B. Lippincott Company.

Freud, A. (1930). Introduction to psychoanalysis. In: Four lectures on psychoanalysis for teachers and parents, (pp. 73-90). New York: International University Press.

Garcia-Preto, N. (1982). Puerto Rican families. In McGoldrick, M. , Pearce, J.K., & Giordano, J. (Eds.) Ethnicity and family therapy (pp. 164-186). New York: Guilford.

Geballe, Gruendel, & Andiman (Eds.) (1995). Forgotten children of the AIDS epidemic. New Haven: Yale University Press.

Goldstein, J., Solnit, A.J., Goldstein, S., & Freud, A. (1996). The best interests of the child: The least detrimental alternative. New York: The Free Press.

Grant, D. (1993). An exploratory examination of the interrelationships among parenting beliefs parenting stress, and parent-child interaction in the context of maternal polydrug addiction and prenatal drug exposure. Unpublished doctoral dissertation, University of Tennessee at Knoxville, Knoxville, TN.

Gustavson, N.S. (1992). Drug-exposed infants and their mothers: Facts, myths, and needs, Social Work in Health Care, 16(4), 87-98.

Johnson, H.L. & Rosen, T.S. (1990). Mother-infant interaction in a multirisk population. American Journal of Orthopsychiatry, 60, 281-288.

Kagan, J. (1980). Family experience and the child's development. Annual Progress in Child Psychiatry & Child Development, 21-30.

Klerman, L. (1991). Alive and well? A research and policy review of health programs for poor young children. New York: National Center for Children in Poverty, Columbia University School of Public Health.

Kusserow, R.P. (1990). Crack babies: Selected modle practices (OIG OEI-038901542) Washington, DC: Office of the Inspector General .

Levine, C. (1995). Orphans of the HIV epidemic: Unmet needs in six U.S. cities. AIDS Care, 7 Suppl. 1:557-62.

Lum, D. (1992). Social work practice & people of color: A process stage approach (2nd ed.). Pacific Grove: Brooks/Cole.

Malakoff, M., Mayes, L.C., & Schottenfeld, R. (1994). Language abilities of pre-school children with cocaine abusing mothers. American Journal of Addictions, 3, 346-354.

Mayes, L.C., & Bornstein, M.H. (in press). Attention regulation in infants born at risk: Prematurity and prenatal cocaine exposure. In J. Burak & J. Ennis (Eds.) Development, attention and psychopathology, New York: Guildford Press.

Michaels, D. & Levine, C. (1992). Estimates of the number of motherless youth orphaned by AIDS in the United States, Journal of the American Medical Association, 268(24), 3456-3461.

Omnibus Budget Reconciliation Act of 1993. Public Law 103-66.

Pinderhuges, E. (1982). Afro-American families and the victim system. In M. McGoldrick, J.K. Pearce, & J. Giordano (Eds.), Ethnicity and family therapy (pp. 108-122). New York: Guildford.

Provence, S. (1979, March 16 & 17). Changing families and child rearing. Prepared for The Children's Advocacy Conference of The New England Children's Mental Health Task Force. Durham, N.H.

Robertson, J. & Robertson, J. (1969). John, seventeen months, in residential nursery for nine days. Distributed by New York University Film Libarary.

Spencer, M.B. (1983). Children's cultural values and parental child rearing strategies. Developmental Review, 3(4), 351-370.

Sue, D.W., & Sue, D. (1990). Counseling the culturally different: Theory and practice (2nd ed.). New York: John Wiley & Sons.

Chapter 6

LOOKING AT BABY, WHAT YOU SEE IS OFTEN NOT WHAT YOU GET: USING THE BAYLEY SCALES TO ASSESS THE DEVELOPMENT OF DRUG-EXPOSED INFANTS

Regina Adesanya, PsyD
Catholic Community Services
Newark, New Jersey

Gambi White-Tennant
Newark Renaissance House
Newark, New Jersey

Darlene Grant, PhD
School of Social Work
The University of Texas at Austin

Introduction

Practice and empirical literatures present significant evidence that suggests that infants prenatally exposed to drugs demonstrate a range of physio-psycho-social symptoms although symptoms vary among children, based on the amount used, the intensity or frequency of use, point during pregnancy when exposed, or the type of drug used by mother (Chasnoff, Griffith, Freier & Murray, 1992; Chasnoff, Landress & Barrett 1990; Grant, 1993). A combination of factors can contribute to differences in the way prenatally drug-exposed infants and young children are assessed in the hospital, day care, and therapeutic treatment setting including, but not limited to, central nervous system effects including neurobehavioral deficiencies, and developmental delays in language, adaptive behavior, fine motor and cognitive skills (Chasnoff, Griffith, Freier & Murray, 1992; Chasnoff, Landress & Barrett 1990; Grant, 1993).

Instances of vacillation between extremes of sleeping or crying during handling, and a stressed and panicked awake state may also influence assessment results (Grant, 1993; Schneider, et. al, 1989). When considering assessment of the prenatally drug-exposed infant we also believe the assessor should be aware that unresponsiveness and/or hyper-responsiveness may result to a degree that hinders successful response during interaction (Grant, 1993). A combination of any of the above factors can impede healthy child development, threaten the quality of interaction between the child and her/his caregivers, and may adversely impact the accuracy of predictions of the future functioning of these infants.

Project B.A.B.I.E.S. (Boarder, Abandoned, Babies, Intervention, Education Services), a Newark, New Jersey program, was developed, in part, to sensitively assess and intervene with infants prenatally exposed to drugs. Ensuring the optimal development of the babies who live at Project B.A.B.I.E.S. is of the utmost concern to the staff and our community. We believe that to have and maintain confidence in the interventive approach being used daily with the babies, an objective assessment, not just our feeling that the babies in our care are doing well, must be employed. We use the Bayley Scales of Infant Development (BSID) as a tool to inform us of our babies' needs and potential.

The BSID is reportedly the most often used assessment tool for infant development. It has frequently been used with children whose development is in question due to premature birth or other birth-associated risk factors. Most commonly, when BSID scores are computed for premature infants, the age of the infant is corrected for the prematurity (Whatley, 1987).

Because of its comprehensive nature, we also employ Bayley assessment results as aids for individualized infant curriculum planning. In this paper we highlight the interdependence between environment, nurturing and the application of sound child development theory, as well as discuss basic practice concerns focused on issues of cultural bias in assessment.

Program Overview

Project B.A.B.I.E.S. was formed in response to the alarming number of prenatally drug-exposed babies being abandoned and subsequently boarded for extended periods of time in Newark, NJ hospitals. The Community Agencies Corporations of New Jersey, utilizing one of its subsidiaries, the Protestant Community Centers, Inc., worked collaboratively with staff from the Infant Toddler Parent Program at the University of Medicine and Dentistry of New Jersey and with the Assistant Pediatric Medical Director of Children's Hospital of New Jersey to develop a community based response to the problem.

Project B.A.B.I.E.S. is located in a one-family house in the North Ward of Newark. The furnishings and set up provide a home-like atmosphere for babies, parents, and staff. Our "good neighbor" policy and outreach approach has served us well as Project B.A.B.I.E.S. has integrated into the neighborhood and has become an accepted entity. Local residents stop by periodically to seek referrals for resources or to ask the advice of the staff. In addition, the provision of 24-hour service has helped to stabilize the area by attracting increased police patrols and neighborly interaction.

The program was developed as an alternative model to housing or boarding babies in a hospital subsequent to medical assessment of fitness for discharge. The program's primary goal is to get babies out of the hospital as soon as they are medically discharged and to work toward their reunification with biological parents if possible. Prior to the development of the program, the length of stay in hospitals for "boarder babies" ranged from 3 weeks to several months, resulting

in babies languishing in the hospital. Even though an attempt was made to provide more than custodial care for the boarder babies while still in the hospital through the use of volunteers, the quality of care was barely adequate.

Project B.A.B.I.E.S.' secondary goal has been to encourage the foster care system to become sensitive to the special needs of abandoned babies by reducing the number of placements babies have before becoming available for adoption or reunification with their families. Prior to the establishment of Project B.A.B.I.E.S., babies awaiting reunification and/or foster care placement might live in 2 to 3 homes before reaching one year of age.

In keeping with the mission of fostering understanding and sensitivity to the needs of prenatally drug-exposed infants, our program conducts in-service training with the Division of Youth and Family Services to educate its staff regarding the negative effect multiple placements have on young infants and conjointly develop a protocol for transitioning infants placed in the Project B.A.B.I.E.S. house to foster care or care with a relative. One of the criteria for foster family eligibility has been that the primary caretaker in the home be willing to consider a long-term placement until a permanent plan for adoption or family reunification, has been finalized.

Since all babies accepted as residents at Project B.A.B.I.E.S. were drug-exposed at birth, the program staff found it imperative to initiate an infant stimulation program based on child development theory, and the results of current research regarding drug exposure in babies (Chasnoff, Griffith, Freier & Murray, 1992; Chasnoff, Landress & Barrett 1990; Grant, 1993). Behavioral and learning theories of child development, for example, emphasize "that learning comes about from the interaction of the person with the environment. Through the interaction with the environment, the child learns various types of behavior...Behavioral and learning theories are concerned with the behavioral indicators of growth and development, as well as cognition and personality development" (Allen-Meares, 1995). In particular, low threshold infants, particularly those drug exposed prenatally need to be stimulated without being overstimulated. Caregivers can be taught to bring infants to alert, responsive states and to stimulate the infants appropriately (Griffith, 1992).

Further, to distinguish the quality of care babies receive at Project B.A.B.I.E.S. from the type of care provided if they continue to board in the hospital, the program decided to maintain low infant-staff ratios and institute a staff development program. There is a minimum of 2 caregiving staff persons present on each shift, as well as a primary caregiver assigned to each baby. This primary caregiver is responsible for updating medical information, recording and sharing developmental milestones, and implementing a daily program for each baby based on the information provided by the Infant Specialist. To insure that the caregivers have the skills to use with the infants, they are required to have a high school diploma and are strongly urged to further their education either through participating in the Child Development Associate credential or attending the early childhood program at the local community college. Program administration further support staff development with monthly in-service training programs

which are provided on site and include modules on CPR, first aid, child development theory, and effects of addiction on parenting and child development.

The caregivers play an important role with the parents of the babies as well. They often show the parents stimulation techniques used with the babies and provide explanations about why they are used. Having the caregivers interact with the parents in this way allows the parents to learn to discuss their child's development in a non-threatening manner and reserves the expertise of the infant specialist for more intensive case conferences. Parents are aware of how important the primary caregiver is to their baby and naturally gravitate toward that caregiver.

Additionally, the caregivers' and the parents' cultural backgrounds influenced care procedures implemented at the Project B.A.B.I.E.S. house. Cleanliness and being impeccably dressed are important to African Americans and Latinos. Although the infants were not going anywhere special, each infant was bathed in the morning and dressed in clothing for their daily activities. In the evening, after their bath, their clothes were again changed and they were dressed in pajamas for the night's sleep. Mothers, as well as caregivers, had input into the types of clothes that were bought with the outfits reflecting the environment from which the babies came.

Maintaining ties to the surrounding community and being able to take advantage of community resources were important considerations in the development of the program. To that end, Project B.A.B.I.E.S. established an advisory board whose purpose is not only to advise the program regarding its operations but also to support the babies and their families by providing services. The advisory board consists of representatives from 17 agencies including medical providers, realtors, mental health professionals, addiction treatment personnel, and Division of Youth and Family Services representatives.

Being culturally sensitive to the particular needs of each baby based on his/her particular ethnic background was of importance in developing the program. Rather than viewing culture as an unrelated feature to the various aspects of intervention within the program, information regarding the workers' need to respond with sensitivity to the babies' cultures is infused throughout the program. Worker cultural responsiveness is addressed in each training module. As Finn (1994) suggests, for example, Project B.A.B.I.E.S.' worker training emphasizes cultural characteristics--such as concerns regarding denial of mental illness, the ability to show true emotions with others which has an impact on the quality of mother/child or caregiver/parent relationships, parenting beliefs and skills, issues of motivation to recover from substance abuse and the impact of these on the client's length of stay in the program. Further caregiver training focuses on the importance of clients' "buy-in" to the therapeutic process and approaches which incorporate cultural and community mores into the process.

Further, a concerted effort is made to develop a culturally diverse staff. The staff's ethnic background reflects the community and the ethnic heritage of many of the babies who are residents of the facility. Both the infant specialist and director are African Americans. The

Project B.A.B.I.E.S.' staff reflect the culture of the local community, in ethnicity, language and background with some staff dealing with recovery issues. The caregiving staff in particular are encouraged to use their other languages, as well as English, when soothing or playing with the babies. There is a sense of shared responsibility for the care of the babies. The program staff work by the African proverb, "It takes a whole village to raise a child." Although assigned a primary caregiver upon entering the program, each child's progress is monitored by all caregivers and each child receives the care and nurturance similar to that of an extended family including diapering, feeding, rocking, and playing.

Ethnic and drug related concerns permeate the meal planning and development of individual daily activities. In an attempt to insure that the food consumed is healthful and to segregate any impact illicit chemicals might have on the infant, their diet and medical regime contains many natural foods and natural medicines (medical treatment approaches), many reflective of Caribbean, African and Latino culture. The daily activities planned for the children are based on the ethnicity and language of both the caregiver and the biological parents. Stories used in the program reflect both African American and Latino traditions. Additionally, large muscle gross motor activities are initiated with the infants early on to ameliorate conditions resulting from their substance exposure.

The information presented in this paper will be helpful to practitioners in AIA and other programs who work with the babies or their parents. Since AIA programs have been established in response to national concerns regarding infant abandonment, planning for the care and insuring the optimal development of the babies remains an imperative. This paper will utilize the results gained from using the Bayley Scales of Infant Development on specific Project B.A.B.I.E.S. residents to demonstrate how a classical assessment instrument can be helpful in planning interventions that are culturally sensitive for use with young clients. Further, the authors will highlight how the Bayley can be used to help evaluate the program, measuring the benefits a program such as Project B.A.B.I.E.S. can have on the babies and their development.

Bayley Scales of Infant Development as an Assessment Tool

The Bayley Scales of Infant Development (BSID) is an assessment tool that measures the mental (cognitive, language, and social), motor (fine and gross) and behavioral (emotional) development in children two months to thirty months of age. This measurement tool is used in various settings, such as hospitals, clinics, and, schools, for many different purposes, such as medical and psychological assessments, research and curriculum planning. The BSID is a tripartite assessment tool that evaluates mental, motor and behavioral development. Although a newly revised version of this assessment (BSID,II) has been recently released, this paper will only discuss findings from assessments conducted using the original BSID. Until the BSID revision, the Bayley, although limited in its ability to distinguish development in premature babies with many risk factors, was the primary infant assessment tool in use. Further, the interpretation of the BSID's results had been compromised, did not reflect the nuances of the baby's development

and often presented the substance exposed infant's behavior in a more favorable light, than actually observed.

The Bayley Scales of Infant Development are organized by age of the child, as well as level of ability. "An infant tends to respond to those situations and tasks which capture his interest. In assembling items for the BSID, an effort was made to obtain measures of relevant behavior variables by means of stimuli which are attractive to the child, thereby engaging his interest and participation" (Bayley, 1969).

Similar to the "ebb and flow" of development, the BSID moves from measuring responses to the less sophisticated stimulation, such as "regards person momentarily", to the more sophisticated, such as "talks and smiles", with several graduated levels of stimulation in between.

The assessment items or situations are not grouped as aforementioned on the protocols because there are other areas of development that need stimulation at the same level. Since the examiner has to present the stimuli and record the response, like situations or items are connected by a technique called Situation Coding.

The mental and motor scales are assigned Situation Codes because development does not happen at one time but rather over a period of time. The Situation Codes allow the examiner to move quickly through the recording of a succession of stimuli/responses of one item. For example, responses to the BSID's rattle item can be observed four different times in the assessment. The responses are at 0.1, 2.9, 3.9 and 4.9 which can be observed through the first five months of the child's development. The Situation Coding designates the letter (c) to each item involving the rattle. If the examiner is assessing a child that is 3 months old, it is likely that the child may respond to the rattle in a manner that can be credited to a child of 3.9 months or even 4.9 months of age. This coding allows the examiner to easily record the different levels of rattle responses without interrupting the child's natural spontaneity and exploration.

The extrapolation of information from the BSID allows the examiner to create a documented developmental picture. These developmental "snap shots" are framed into a developmental plan and used as an individual curriculum guide at Project B.A.B.I.E.S. The BSID was developed at a time when not much attention was paid to the differences in development that might be presented by African-American infants, but the information gained as a result of the BSID can be filtered through the eyes of a culturally sensitive examiner.

The BSID is administered one month after the infant's placement into Project B.A.B.I.E.S. This grace period of one month allows the infant to become acclimated to his/her new environment. Although, Project B.A.B.I.E.S. has a more home-like environment, the infant undoubtedly receives more tactile, olfactory, visual and audio stimulation at Project B.A.B.I.E.S. than he/she received in the hospital. The voices of adults and children are constantly heard. This initial

difference, from a sterile, brightly lit, hospital environment to a home-like setting can be stressful to an infant.

After this one month grace period, the infant is assessed every other month to ascertain the quality of development, to pinpoint actual development, and to formulate a developmental plan. This schedule is affected by the infant's well-being and ability to tolerate the entire assessment. The assessment findings also determine whether a referral is needed for the infant to receive additional services.

The area used to conduct assessments is located on the top floor of Project B.A.B.I.E.S., which is away from the traffic area of the facility. The room was purposely painted a warm beige color to guard against any heightened stimulation. The room is of average size (12'x12') and contains only two pieces of furniture (a desk and a file cabinet). The infants are slowly carried upstairs by their familiar caregiver. They are allowed time to inspect the room from the caregiver's lap. The examiner, who is also familiar to the infant, casually talks with the caregiver about any concerns or occurrences that might have been noted about the infant. This exchange usually helps the infant to become more relaxed.

The assessment is introduced in a slow and easy manner to prevent the child from becoming overstimulated, which can easily happen within such a young population as well as within the prenatally substance-exposed population. If the infant does become overstimulated, the assessment is temporarily stopped. If the infant can be consoled, the assessment will then resume. If not, the assessment will be terminated and rescheduled for another time or day when it can be readministered.

The infants discussed in this paper are all African-American and born substance-exposed. These babies received a positive toxicology screen for cocaine at birth. The hospital records of these babies reflect mother-reported usage of cigarettes and alcohol. The names of the two infants discussed in greater detail in this paper are fictitious but their developmental information is factual. Justin and Monique are the names of the infants whose development will be discussed.

Justin

Justin entered Project B.A.B.I.E.S. at one month of age. He is his mother's ninth child and was several weeks premature, weighing 6 pounds. He tested positive for cocaine at birth and his mother voluntarily reported that she used cocaine and alcohol and smoked cigarettes throughout her pregnancy.

Although Justin entered Project B.A.B.I.E.S. at one month of age, he was not formally assessed until four months later due to a series of medical problems. He had continuous ear infections with high fevers, numerous bouts of thrush, frequent wheezing episodes, and a serious attack of gastroenteritis. All of these illnesses prevented any formal developmental assessments from being conducted.

Only observational assessment could be made of Justin's development during this time span. These assessments found Justin to be hypotonic, or having low muscle tone. His eye muscles were also weak which made one of his eyes occasionally "dance." This infrequent eye movement did not render Justin unable to track objects or people. He did not seem to recognize when his eyes moved out of position with each other, nor did he attempt to self correct his eyes during these times.

Justin showed no early signs of having self-comforting techniques. He never brought his hands together or tried to mouth them. Instead, his arms remained listlessly by his sides. His legs extended, and his feet were held with the heels together. Justin progressed from turning his head from side to side, in the prone position, to lifting his head and then elevating his upper torso with his arms. Although he successfully moved through these levels of motor development in his upper torso, his lower extremities remained extended and hypertonic. Due to his easy irritability which might have been due to his substance exposure and/or his fragile health status, Justin was not formally assessed until he was five months old gestationally.

Justin eventually found his hands and without prompting began to put them in his mouth. Also during this time, Justin would attempt to reach for objects in his viewing field and would deftly pick them up. His eye-hand coordination became very precise and smooth but his grasp remained immature. As his upper extremities developed and matured, his lower extremities remained extended and hypertonic. Exercises to rotate his hip were administered through play but no significant change was noticed. Also, during this time Justin made no sounds. He displayed a limited array of emotions by smiling, frowning, and crying and communicated through facial expressions and gestures. Justin was able, however, to give very clear clues through his learned skills. For example, if he was given a water bottle but wanted a formula bottle, he would briskly throw both of his arms into the air and clasp them at the wrists over his head. He would then cry with great vigor, which usually caused him to perspire. Justin was very difficult to soothe and eventually began to suck his thumb as he rubbed something (i.e., his shirt or blanket) against his cheeks to calm himself.

At Justin's first formal assessment, he displayed all the skills that had been noted in the informal observations. Justin was placed in a high chair where he displayed no control over his trunk.

Several times during the assessment Justin slid to one side or down into the high chair, and never tried to self correct. He required support to maintain an upright position in the high chair.

The assessment was conducted at a slow and easy pace but Justin still displayed moments of overstimulation which he was able to control. When his breathing became rapid and his body stiffened, he would immediately suck his thumb. After he calmed himself, he would remove his thumb from his mouth and begin to act upon whatever was before him.

For example, during the introduction of the red blocks which is part of the cognitive piece of the BSID mental scales, Justin examined the block visually, mouthed the block, and transferred it from one hand to the other. When the second block was introduced, Justin became so excited that he popped his thumb into his mouth and looked with wide-opened eyes at the examiner. When his body became relaxed and his breathing controlled, he took his thumb out of his mouth, picked up one of the red blocks, and continued to mouth it. This example showed Justin's ability to regulate his stimulation, which required awareness and control. There were several occasions during the assessment when Justin stopped participating and began to suck his thumb to soothe himself for a few minutes. These occasional "timeouts" could be predicted by Justin's rapid breathing and stiffened extremities.

Justin was able to tolerate the Mental and Motor Scales of the assessment although he began to reflux at the end. Justin's indexes in the Mental and Motor Scale were 100. Since this score was high for his chronological age, there was no need to adjust the score for his premature birth.

The interesting part of these findings was Justin's Motor Scale index. The assessment did not reflect Justin's hypertonic trunk which is so obvious to the observer. Although Justin could respond to the examiner's requests, the quality of the task performed is not indicated in the test score. For example, one item on the BSID Motor Scale required the child to "pull to standing position." The item is checked either "Pass" or "Fail". Justin was able to pull to a stand and earn a passing score, but did so only with great difficulty. Because of his hypertonic trunk, Justin had to use virtually 98% upper body strength to get into the position. His entire body trembled and his feet were misaligned beneath him.

Justin's next formal assessment was conducted when Justin was 11 months old. Aside from a few occasional ear infections, Justin's health had improved. By this time, Justin had added deep grunting sounds to his repertoire of communication skills. He was also laughing out loud and smiled easily. Instead of visually inspecting the examination room from a safe place, Justin slid off the caregiver's lap onto the floor and began to inspect physically by crawling. He crawled on both hands and knees but his feet remained pointed outward from his body. Justin again responded to every item presented. He remained engaged throughout the entire assessment and displayed no signs of over-stimulation. Justin continued to rely heavily on his upper body to maneuver himself from prone to upright and from upright to standing.

Although he continued to compensate for his trunk area with his upper torso, his movements had become smooth. As Justin cruised around furniture and other objects in the room, his feet remained pointed completely outward, making his heels face each other. His feet were also without arches. Again, Justin's ability to carry out the required tasks of the assessments did not reflect these issues. Justin's indexes were 114 for the Mental Scale and 104 for the Motor Scale. Referrals were made for a hearing and orthopedic screening.

The referral for a hearing screening was made for two reasons. First, Justin's initial language development was assessed to be significantly delayed. Although language development in substance exposed children is usually delayed, Justin's was significantly more delayed. When he began to make sounds, they were so deep that many times he would choke on his saliva. These very deep and guttural sounds turned into grunts without any intonation or change of pitch. Coupling these concerns with his medical history of numerous and frequent bilateral otitis media or ear infections in both ears required a hearing evaluation/screening. Justin's hearing screening did not find any hearing loss or deficits. The speech therapist had no recommendations for his language development except to monitor it.

Justin's orthopedic screening referral was made because of the low muscle tone in his trunk area. Although the physical therapist found Justin's feet placement to be strange, no further referrals were made due to his age. The physical therapist recommended exercises and certain toys which were already being used at Project B.A.B.I.E.S. for intervention in this area.

Monique

Monique, an African-American female, is the third and youngest child in her family. Her other two siblings are in foster placement. Monique was born at 36 weeks gestation weighing 4 pounds 6 ounces. Although she was premature, she was still considered small for her gestational age. Monique tested positive for cocaine which her mother denied using. The medical reports document Monique's mother voluntarily reporting tobacco and alcohol use throughout the pregnancy but denied the use of any illicit drug.

Monique entered Project B.A.B.I.E.S. at nine days old. She was so tiny that size 0-3 months were too big. Due to her prematurity, Project B.A.B.I.E.S. adjusted for gestational time for assessment purposes. Accordingly, only observational assessments were conducted. These assessments found Monique to have static-like movement. She could be easily engaged but was not able to control the amount of stimulation she received. For example, gently talking with Monique while making eye contact would cause her to overstimulate. Her arms and legs would begin moving sporadically in all directions during the first few seconds of engagement. As the interaction would proceed, Monique's legs and arms would move as though she was drowning. She never stopped the interaction by turning away or crying. This frantic movement

would continue until the person stopped the interaction. Monique's facial expression did not change during these overwhelming interchanges. She continued to maintain eye contact and move her mouth as though she was going to speak. The only difference that would occur was the rapidity of her mouth movements which were not as frenetic as her arm movements. Generally, the participant in the interaction would stop the stimulation when Monique would begin to reflux, hiccup violently or sneeze.

Monique was able to track objects but her attention to the object was very brief. She would maintain longer interest in tracking human faces. Her body, in its normal state, remained tense. When Monique was placed in a supine position she would hold her arms tautly out to the side of her body. If she was placed in a prone position, her arm positioning would be the same. Monique did not bring her arms inward to her body in any position. During her feeding, Monique would lay in the caregiver's arms with her arms stretched stiffly out from her body. Her first sounds were screeching noises. These sounds were very similar to nails on a chalkboard. Monique would make these sounds when she was interacting. No matter who would talk to her, the interaction was the same. According to the Bayley assessment, she showed no differentiation among the caregivers or towards strangers. Monique could be easily engaged by anyone.
Monique did not receive a formal assessment until she was 4 months-old chronological (3-months-old gestational). The reason for the delay in Monique's initial formal assessment was due to her prematurity, severe bouts with ear infections and viral gastroenteritis. Her first formal assessment found her to be very hypertensive (tight, taut) in her upper extremities with a little more flexion, than previously observed, in her lower extremities. Monique regarded any item brought into her field of vision. She would move her legs, kick her feet and/or smile at the object or the person presenting the object.

Monique made no attempts to reach for objects or bring her hands close toward her body even if the object was placed in close proximity to her. Her fingers would wiggle when something new was presented but she did not relax her arms or bring them in towards her body.
Unlike earlier observations, the assessment found Monique's arm placement to be down at her side instead of out at the sides. Although they were still tautly held, she had brought them in towards her body.

The Motor Scale of this assessment found Monique to be in control of her head movements and her upper torso. Although she maintained herself well throughout the assessment, she began to reflux at the end of the Mental Scale and began laying her head on the floor while sucking her fingers at the end of the Motor Scale. Monique's chronological indexes were Mental 74, Motor 102 and when corrected for gestational age, her Mental was 90 and Motor 117. The high Motor index suggest average to above average motor development. However, in reality, Monique's motoric responses were hindered by hypertonicity. The Bayley results did not reflect the nuance

in actual behavior. Due to prematurity, Monique's gestational indexes were regarded as her assessment scores.

The next formal assessment of Monique was conducted at 7 months of age chronological (6 months of age gestational) and when she weighed 13 pounds which was proportionate to her height. This assessment found Monique to move her extremities in a fluid and controlled manner. There was no waving about--she demonstrated, instead, straight and efficient movements to retrieve. She was crawling, climbing and pulling to a stand in smooth movements.

Monique's pre-language skills had developed from screeches into more rounded sounds. Her babbling was continuous throughout the assessment and was full of intonation. She used numerous skills to communicate (gestures, babbling, facial expressions). Monique also displayed a strong dislike for one of the assessment items, "dolly". She looked at the doll and began to frown. Her frown eventually turned into a full fledged scream and she immediately turned to her primary caregiver. The doll was removed and after a few moments Monique regrouped and reentered the assessment.

This assessment reflected Monique's indexes to be Mental 92, Motor 94 (Chronological) Mental 111, Motor 110 (gestational).

Interpeting the Bayley Beyond Statistical Data

The variation between the Bayley assessment findings and actual observations epitomized "...What you see is often not what you get...". Although the child could accomplish certain tasks, the manner in which the task was accomplished was not always reflected in the assessment. For example, Justin could definitely sit up without support and would get credit for this item on the Bayley. However, his ability to maintain control of his muscles was questionable. Another example was that the method Justin used to pull to a stand required tremendous use of his upper body muscle. Based on the Bayley items: Could he pull to a stand? The answer would be an emphatic "yes." Did he follow the typical physiological progression? No. One concern with Justin was his growing ability to manipulate his body to compensate for his deficits. Although this was not an appropriate ability, we need to examine the "why" of his compensation to accurately develop an intervention plan. If the protocol had been the only documentation of Justin's development, this concern might have gone unnoticed. The cultural context of the child's caregiving environment is most important to understand and use in interpreting the child's developmental capability (Greenspan & Meisels, 1993).

This same concern was evident in Justin's and Monique's language development. Both babies had quite unusual first sounds. They did not make typical babbling and cooing sounds of infants but rather squawks and screeches that would pierce the environment. Did they make distinctly different sounds using squawks and screeches? Yes. Did they use these sounds to communicate?

Yes. Again, the ability to verbalize was present but the manner of verbalizing was questionable. From the perspective of the caregivers, the "noises" made by the babies were intolerable and definitely not acceptable; this viewpoint came about as a result of their cultural perspective which for many included the old adage of "children should be seen and not heard" and "adults have little reason to communicate with children." Individualized developmental plans were developed using the identified developmental areas of strength according to the Bayley to facilitate the intervention and took into consideration the needs of the caregiving staff.

Although Monique responded to the intervention and began to round out her screeching sounds, Justin was less responsive to the intervention. A sensitivity to the high risk of language delays in prenatal substance exposed babies was consistently present in the environment. The use of language by the caregivers consisted of: talking softly with the babies in English and Spanish, talking through activities/routines in which both caregiver and baby were engaged. This provided a rich and colorful language-stimulating environment. In many instances when the babies began to develop more language skills their cognitive skills also improved.

These are only a few examples that reflect the importance of observation and cultural awareness in the assessment process. Assessment information alone does not provide an accurate picture of the child which, of course, affects the quality of intervention planned.

Implications for Practice

Whatley (1987) suggests the following as important considerations when administering the BSID:

- The examiner is a stimulus toward whom the parent and/or child responds.
- [Test] administration should be guided by the child's interest, energy, and attention.
- Clinical judgment plays a role in decision-making concerning the extent to which the child's performance is a fair representation of his or her ability. Such judgment is also called into play in developing hypotheses concerning the pattern of results that make up a given score. Unfortunately, the manual offers little to educate or facilitate interpretation of scoring beyond statistical and standardization data.

The cases of Justin and Monique provide information that suggest a range of complexity when assessing infants with prenatal exposure to alcohol, tobacco, and/or illicit drugs, from easy irritability to easy engagement, for example. Using the three points from Whatley, listed above, and the guidelines for culturally responsive workers presented by Finn (1994) the challenge for the administrator of psychological assessment tools includes: (1) avoiding the stereotyping of infants who have been prentally drug-exposed as all or none in terms of deficits and future

functioning capabilities; (2) avoiding the stereotyping of the mother with drug-addiction problems as an incompetent and/or unreliable parent; (3) individualizing assessment guided by the child's interest, energy, and attention; (4) avoid assumptions, jumping to conclusions, and acultural misinterpretation of behaviors that may be considered problematic when taken out of cultural and societal context, and "modify clinical approach in order to develop [mother's and child's] trust" (Finn, 1994).

Further, the addiction treatment and other social service worker is encouraged to discern cultural issues that may affect the responsiveness of mother, caregiver and/or child during the assessment process. To facilitate the assessment, the child's mother may be asked to interact with the child so that the interaction may be observed. In the case of 5-month-old Justin, had his mother been present and the BSID administrator of Anglo descent not attuned to the above cautions, Justin may have been sensitive to his mother's discomfort and even more easily irritated and difficult to soothe during the interaction. In such an instance, the protocol requiring a "room that is pleasant but not distracting" (Whatley, 1987) for optimal test interaction is what you might see, but not what you might get, as the distraction to the child becomes one that is more internally driven.

Another example of what you might see versus what you might get would be the case of 4-month old Monique who is easily engaged by the BSID examiner and easily overstimulated but never turns away while flailing arms and legs until the examiner moves out of her visual and auditory fields. The kindly, culturally sensitive, and responsive examiner as a stimulus toward whom the child responds, is not always going to garner a positive response from similarly responsive children. Subsequently, clinical judgment, that is grounded in knowledge about prenatal substance abuse and its affects, as well as cultural and child development information, is critical to good decision-making and judgment in representing and assessing the child's performance.

The examiner and other social service providers may extend themselves to include consultation with a social worker, MD, outreach worker, and/or psychologist of color to gain insight into the psychology and sociological functioning of clients of color. Consultation is presumably the approach of choice to educate and facilitate more accurate interpretation of client behaviors and scoring of psychological examinations.

The assessment process for babies, especially those who have substance exposure risk factors, must be based on an integrated developmental model which takes into account the cognitive, language, motor, sensory and social capacities. These assessments can only occur in the context of their cultural and relationship environment and take into consideration not only information presented as a result of the formal assessment tool but also make use of available observational and anecdotal data. Further, as indicated above in the description of the Bayley results, the quality as well as the developmental sequence must be considered in making judgments about the child's actual development in order to recognize that the baby's growth is a dynamic (Greenspan & Meisels, 1993).

Dana (1995) provides four conditions to consider when interpreting psychological test results in the context of cultural difference including: (1) unwitting distortion of information; (2) rendering the assessed more disturbed than in fact they are; (3) stereotyping which presents a caricature that distorts the personality or emotional state of the person being assessed; and (4) dehumanization by use of personality theories which do not account for other cultural frameworks. Ideally, the culturally competent examiner and other social service provider will guard against these prejudices during the assessment and interpretation process. Viewing pregnant and/or parenting women with substance abuse problems and children as "drug-exposed" as pathological or defective is of critical concern in the addiction treatment and recovery field. Caution is advised in using psychological or other assessments for anything other than descriptive and/or treatment purposes with the assessor being aware that the formal tool should not be the sole basis for judgment and planning.

References

Allen-Meares, P. (1995). Social work with children and adolescents. New York: Longman.

Bayley, N.B. (1993). The Bayley Scales of Infant Development. New York: Psychological Corporation.

Bayley, N. (1969). Bayley Scales of Infant Development. San Antonio: The Psychological Corporation.

Chasnoff, I.J., Griffith, D.R., Freier, C., & Murray, J. (1992). Cocaine/polydrug use in pregnancy: Two-year follow-up, Pediatrics, 8(9), 284-289.

Chasnoff, I.J., Landress, H.J., & Barrett, M.E. (1990). The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. New England Journal of Medicine, 1(3), 666-669.

Dana, R.H. (1995). Impact of the use of standard psychological assessment on the diagnosis and treatment of ethnic minorities. In J.F. Aponte, R.Y. Rivers and J. Wohl (Eds.) Psychological intervention and cultural diversity. Boston: Allyn and Bacon.

Finn, P. (1994). Addressing the needs of cultural minorities in drug treatment, Journal of Substance Abuse Treatment, 11(4), 325-337.

Grant, D. (1993). An exploratory examination of the interrelationships among parenting beliefs. parenting stress. and parent-child interaction in the context of maternal polydrug addiction. Unpublished doctoral dissertation, The University of Tennessee, Knoxville.

Greenspan, S.I., Meisels, S. (1993). Toward a New Vision for the Development Assessment of Infants and Young Children. Distributed to participants in Zero to Three Biennial National Training Institute.

Griffith, D.R. (1992). Developmental/educational prognosis for children exposed to cocaine and other drugs prenatally. Phi Delta Kappan, 74(1), 30-34.

Sattler, J.M. (1988). Assessment of children. (3rd ed.). San Diego: J.M. Sattler.

Schneider, J., Griffith, D.R., & Chasnoff, I.J. (1989). Infants exposed to cocaine in utero: Implications for developmental assessment and intervention, Infants and Young Children, 20, 25-36.

Whatley, J.L. (1987). Review of the bayley scales of infant development. In D.J. Keyser & R.C. Sweetland (Eds.), Tests Critiques: Vol. 6. (pp. 38-47). Kansas City, MO: Test Corp. of America.

SUMMARY

This monograph touches on several different levels of intervention and staff involvement in which a lack of cultural sensitivity and competence could negatively impact our clients. An underlying theme throughout the monograph is that cultural sensitivity and competency is an evolving process that involves individuals (workers and clients) and organizations. Realistically, cultural sensitivity and competence do not happen overnight. We must, however, throughout the process, work to change our cognitive structures which were developed in a society where cultural diversity has historically not been viewed positively. Daily, we must ask tough questions of ourselves and our programs.

- Do I believe/buy into the ideal that learning about and becoming culturally competent enhances our clients' chances for change?

- Am I willing to let the drug-addicted client from certain cultures teach me about her culture? Will I use what we learn from her to individualize her treatment so as to maximize the benefit she obtains from program involvement?

- Do I inadvertently consider individuals from certain cultures as being less likely to benefit from insight oriented counseling, rehabilitation, or any form of intervention we have designed?

- Have I designed a program for clients more similar to ourselves, increasing their chance for recovery and decreasing or not addressing other's chances for success?

- Am I aware enough of cultural differences in our clients to be able to develop treatment plans based on a strengths model versus a deficit model?

The process is not easy, but it is critical if we are committed to quality services.

About the Editors

Darlene Grant, Ph.D., is an Assistant Professor in the University of Texas at Austin, School of Social Work, where she teaches research methods, human behavior and social environment, cultural diversity, and practice with individuals and families in the mental health and chemical dependency concentration. Darlene received her MSSA from Case Western Reserve University in 1984. As a practitioner she has worked as an advocate and counselor in a shelter for battered women, a psychiatric social worker, treating sexually abused children and adults, a family therapist in the adult chemical dependency treatment unit of a psychiatric hospital, director of an outpatient adult children of alcoholics treatment program, and a co-director of a half-way house for women in a joint venture. Darlene entered the doctoral program in social work at the University of Tennessee at Knoxville in 1988, completing the degree in December 1993. Her dissertation was *"An Exploratory Examination of the Interrelationships Among Parenting Beliefs, Parenting Stress, and Parent-Child Interaction in the Context of Maternal Polydrug Addiction and Prenatal Drug Exposure."* She has published in the areas of cultural competence training, women and addiction, prostitution, and women in prison and their children. She is active in public service, and has served on several Advisory Boards of local and national organizations.

Jeanne Pietrzak, M.S.W., is Director of the National Abandoned Infant Assistance Resource Center. In her tenure with the University of California at Berkeley, Family Welfare Research Group, Ms. Pietrzak has directed numerous projects focusing on drug- and HIV-affected children and families, including the Child Welfare & AIDS Project, the Caregiver Training Project, the Study of Services for Drug- and AIDS-Affected Infants, and an evaluation of a community-based Medically Fragile Respite Care Program. Ms. Pietrzak has written numerous reports and articles on drug- and AIDS-affected children, is co-author of *Families Living with Drugs and HIV: Intervention and Treatment Strategies* and is principal author of *Practical Program Evaluation: Examples from Child Abuse Prevention.*

Richard P. Barth, Ph.D., is the Hutto Patterson Professor in the School of Social Welfare, University of California at Berkeley, where he teaches child welfare practice, policy, and research courses. He is the Principal Investigator of the National Abandoned Infants Assistance Resource Center. He is also Co-Director of the Family Welfare Research Group, where he has led numerous studies and demonstration projects on children's services. He is the author or co-author of several books including *Families Living with Drugs and HIV: Intervention and Treatment Strategies* (Guilford, 1993) and *The Tender Years: Toward Developmentally-Sensitive Child Welfare Services* (Oxford, in press). He has been a Fulbright scholar and a winner of the Frank Bruel Prize from the University of Chicago for child welfare scholarship.

About the Authors

Regina M. Adesanya, Psy. D., has a doctorate of psychology from New York University and a Master of Arts in Early Childhood Education from Kean College of New Jersey. Formerly an administrator of Project B.A.B.I.E.S. in Newark, NJ, is currently the Deputy Executive Director of Catholic Community Services of Newark.

Jean Adnopoz, M.P.H., is an Associate Clinical Professor and the Coordinator of Community Child Development Programs at the Yale Child Study Center. She is a graduate of Wellesley College and received her MPH from the Department of Epidemiology and Public Health, Yale School of Medicine. She is the Principal Investigator for the Women and Infants Support Program (WISP), an Abondoned Infants Assistance Program.

Bonnie Buntz, M.A., has been involved in the substance abuse treatment field for the past 14 years. As the Perinatal Program Coordinator for the San Joaquin County Office of Substance Abuse, she developed coordinated services for pregnant and post-partum substance abusing women and their children and developed two model demonstration grants. She has also acted as a consultant for the National Public Health Institute on Health Care Reform.

David W. Campt, M.P.P., Ph.D., received his doctorate from the City and Regional Planning department at the University of California at Berkeley. His dissertation explored the definition of culturally competent service delivery for several organizations serving African-Americans. Mr. Campt has worked extensively as a consultant to addiction treatment and other social service organizations wanting to clarify and improve the cultural competency of their operations. In addition, Mr. Campt is employed by the Center for Reproductive Health Policy and the Clearinghouse for Drug Exposed Children, both of which are research units within the University of California at San Francisco. In his work for these institutions over the past several years, Mr. Campt has served as a program evaluator, with an emphasis on the organizational functioning of agencies that serve people of color.

Cynthia Childress, R.N., B.S.N., P.H.N., has held various maternal/child health positions over her professional career. She developed and implemented Black Women's Initiative, a Black infant health project based at San Joaquin General Hospital. She also acted as the Hospital Pediatric Charge Nurse, Public Health Nurse, Childbirth Educator, Family Planning Coordinator and Perinatal Education Coordinator.

Shirley M. Davis, M.S., has a BS from Case Western Reserve University in Cleveland Ohio, and her MS degree from Syracuse University. She is a doctoral candidate in Educational Administration at Syracuse University. Ms. Davis is a national trainer on women's issues in treatment and the treatment of substance-exposed children. She states "What is needed is early intervention. With intervention these mothers and their children can be successful. We must have high expectations for their success and rehabilitation."

Kim Donoghue, M.S.W., has a BA in Psychology from Buffalo State College and a Masters in Social Work from the State University of New York at Buffalo. She has worked at the Parents and Children Together (P.A.C.T.) Program since its inception seven years ago, providing social services to children prenatally exposed to cocaine and those affected by HIV. She states "I have seen firsthand how the belief that a woman is a 'bad mother' because of her drug use, as well as disrespect and hostility, alienates her from services."

Frances Hutchins has 14 years experience designing and implementing innovative programs for women and children. She is currently the director of a substance abuse treatment program for women with young children. She has also developed a low-cost supportive housing program for women in recovery and a perinatal outreach program for the San Joaquin County Office of Substance Abuse. As an administrator for the Women's Center of San Joaquin County, she designed and implemented a safe shelter and counseling program for battered women. She is the author of a nationally distributed handbook on family violence, Why Does She Stay?.

Judith Ray Jones, Ph.D., is a consultant with the San Joaquin County Office of Substance Abuse. She has been interested in and involved in women's programs for the past 20 years, first as a director of the Women's Center of San Joaquin County and later as a consultant to the Women's Center and a number of private and public agencies that provide services for women and their children. She has both designed programs and written proposals to address the needs of battered women and their children, sexual assault survivors, women who are unemployed or underemployed, women in prison, and women with substance abuse problems and their children. She is the author of two handbooks, Stepping Into the World of Employment and Untying the Knot of Sexism.

Laura W. MacDonald, M.A., is the Evaluation Coordinator for Operation PAR, Inc. She has a Masters in Sociology from the University of South Florida and is completing doctoral studies in Sociology with a minor in Economics at Louisiana State University. She conducts training on culturally appropriate interviewing and assessment techniques with mothers with substance abuse problems.

Lora-Ellen McKinney, Ph.D., is a pediatric psychologist who has worked extensively with children and families involved in health and social service systems. She has served as a consultant to local, state and federal policy agencies and trained health professionals to recognize the social and emotional components of child health. She is currently a Mid-Career Fellow at the John F. Kennedy School of Government at Harvard University.

Gambi White-Tennant, M.S.E., has a Masters of Science in Education from Bank Street College of Education in New York. Formerly with Project B.A.B.I.E.S., Ms. White-Tennant is currently a consultant with Newark Renaissance House where she conducts developmental assessments for children 0 to 5 years old. She is also the Associate Director of Project ERA at JFK Hospital. In this position she is Assistant to Gordan Williamson, Ph.D., the internationally recognized researcher and author in the area of infant mental health. Gambi states that "Newark Renaissance House is currently establishing an Infant Mental Health Program which is exciting and cutting edge."

Terry L. Wright, M.S.W., has a Bachelors in Social Work from Niagara University, Niagara Falls and a Masters in Social Work from the State University of New York at Buffalo. She has worked at P.A.C.T. for 3 1/2 years as a advocate for pregnant and parenting substance abusing women. She states that "I have learned the complexity of problems which these families face. We cannot effectively address the substance use issues until these families' basic needs are met."

Wendy Ann Wyatt, M.S.W., Tracy Washington, M.S.W., and Steven Nagler, M.S.W., members of the clinical faculty of the Yale Child Study Center, worked as co-authors with Ms. Adnopoz. The co-authors work collaboratively to develop programs providing supportive services for HIV and cocaine affected women and their children. They share a commitment to preserving family relationships whenever possible within the context of addressing the developmental, physical, education, social and psychological needs of children and adolescents.